PROVIDER VERIFICATION OF PHYSICAL / MEDICAL DISABILITY

Student Name: ______________________________ Student ID: _____________________________

ESA_________________________________ Type__________________

To the Student:

The form below the line must be completed by your medical provider who is qualified to diagnose and treat your disability. UIU Student Accessibility Services reserves the right to request additional documentation or contact your provider for additional information. If this form is completed by anyone other than a qualified licensed professional, the information will not be used to support your accommodation request. Inaccurate and incomplete documentation may hinder the university ability to accommodate you based on its policies and procedures.

Please sign the box below to give your medical provider authorization to release information to Accessibility Services.

I, __________________________, authorize my medical provider to release to Upper Iowa University Student Accessibility Services the medical information requested on this form for the purpose of determining appropriate accommodations for my disability while a student at UIU.

Patient Signature: ________________________________ Date: ____________________________

<u>*This authorization and consent will expire one year from the date of authorization.</u>

The section below is to be completed by the medical provider.

The above is a student of Upper Iowa University. The student has requested a reasonable accommodation for a disability under the Americans with Disabilities Act (ADA) and has identified you as the treating physician. To assist UIU in evaluating this request, please answer the following questions. Please provide specific and detailed answers to these questions, using additional sheets where necessary. The information you provide will be confidential.

PART I: Questions to determine whether a student has a disability.

Are you the student's primary care provider? Yes No

When did you first meet with the student regarding this mental health diagnosis, and in what context and frequency (that is, was it a face-to-face meeting or virtual interaction)?

When did you last interact with the student regarding this mental health diagnosis?

Have you examined the student for the disability relating to their request for a reasonable accommodation? Yes No

If yes, please provide date(s) of examination:

Please list the student's relevant medical or mental health diagnosis(es) that falls under your scope of practice.

Does the student have a documented disability as determined by ADA? Yes No

If yes, what is the specific disability?

Answer the following question based on what limitations the student has when his or her condition is in an active state and what limitations the student would have if no mitigating measures where used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, learned behavioral or adaptive neurological modifications, psychotherapy, behavioral therapy, and physical therapy. Mitigating measures do not include ordinary eyeglasses or contact lenses.

PART II: Questions to determine whether an accommodation is needed.

A student with a disability is entitled to reasonable accommodations only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability.

Does the impairment substantially limit a major life activity as compared to most people in the general population? Yes No

State a minimum of one major life activity of the student that limits their ability to function due to the student's diagnosed disability?

Explain how the accommodation is necessary for the resident to use and enjoy University housing as compared to a person without a disability.

What function(s) of collegiate life is the student having trouble performing or accessing because of their diagnosed disability?

Taking into consideration the responsibilities associated with properly caring for an animal while engaging in typical college activities and residing in campus housing, do you believe these responsibilities will exacerbate the resident's symptoms in any way?

What specific symptoms have been or will be reduced by having this ESA?

If the identified ESA has a current relationship with the resident, what evidence is there that this ESA has helped the resident?

Is this a short-term or long-term condition?

What other therapies have you tried with the student?

What is the ongoing treatment plan for the student?

Is there another accommodation that would be equally effective in allowing the resident to use and enjoy University housing, if the requested accommodation is not possible?

PART III: Questions to help determine effective accommodation options.

If a student has a disability and needs an accommodation, the university must consider a reasonable accommodation, unless the accommodation poses an undue hardship or it is a fundamental alteration to the course. The following questions may help determine effective accommodations:

Do you have any recommendations regarding possible accommodations for Accessibility Services to consider? Yes No

If yes, what are they?

What additional support(s) is the student receiving to help overcome these barriers?

How would your recommendations specially mitigate the student's disability and improve their educational performance?

Is the animal named here one that you specifically prescribed as part of treatment for the student? How is the animal named here important for treating the student's disability-related symptomology?

Is there evidence that this ESA or an ESA has helped this student in the past or currently?

Have you discussed the responsibilities of properly caring for an animal while engaged in typical college activities and residing in campus housing?

PART IV: Other Comments:

I certify that the above-named patient needs reasonable accommodations as described above due to a diagnosed disability. My signature verifies that I am currently treating this patient, and that the above information is true and accurate.

*Medical Provider Name: (please print) ________________________________

*Medical Provider Signature: ____

* License #_______________________________

*Date: __________________

*Office Telephone Number: _______________________________

Facility Name or Private Practice: ____

Address: (Include Street name, City, State, & Zip Code) ________________________

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Thank you for taking time to complete this information. Please return this form (and any additional information or attachments) from your office email directly to accessibility@uiu.edu

This office may not accept medical information directly from a student.

References: Iowa Code sections 216.8B and 216.8C

Resources: https://icrc.iowa.gov/, 515-281-4121, 1-800-457-4416

This document may contain privileged and confidential information and/or protected health information intended solely for the use by the recipient housing provider. Please exercise care to avoid dissemination.