Thomas Jefferson University

Student Accessibility Services
East Falls Campus

4201 Henry Avenue
Philadelphia, PA 19144
T 215-951-6830

PROVIDER FORM
Medical Documentation of Disability for Special Consideration in Residence Life
(To be completed by licensed healthcare provider who is specialized in specific area)

Patient Name: _____ Date: _____

Diagnosis:
_____
_____
_____
_____

Date of Diagnosis: _____

Date of last office visit:_____

Level of severity (please circle): Mild Moderate Severe

Medications:
_____
_____
_____

Does medication(s) relieve symptoms?
_____
_____

Please list side effects experienced by individual as related to current medications.
_____
_____
_____

A Disability is defined under the Americans with Disabilities Act as "a physical or mental impairment which substantially limits a major life activity"

Based on the above definition of disability, do you feel that this individual exhibits a substantial limitation in a major life activity (ies)? ____Yes ____No

Please list major life activities which are limited and linked to functional limitations. Form will be incomplete if functional limitations are not indicated in full. Be specific with limitations in higher education. (Decrease anxiety and depression is not specific)

Major Life Activity Functional Limitation(s):

_____
_____
_____
_____

What is the expected duration of impairment?

_____
_____
_____
_____

Please discuss expected long term effects of condition.

_____
_____
_____
_____

How many days/months did the impairment limit major life activities during the past year?

_____
_____
_____
_____

Last hospitalization for condition _____

Last exacerbation of condition _____

What accommodations, as linked to functional limitations, are recommended to support this individual in residential living?

_____
_____
_____
_____

Functional Living Recommended Accommodation (please provide alternative accommodations if applicable)

_____
_____
_____
_____

Role recommended accommodation will play in treatment plan

_____
_____
_____
_____
_____
_____
_____
_____

Why is this accommodation necessary and how will it impact the student's ability to live in the residence hall? (With respect to Air Conditioning, please be specific and detailed as to how AC will limit the student's behavior and be harmful without.)

_____
_____
_____
_____
_____
_____
_____
_____

In certain instances, Student Accessibility Services needs to contact the provider regarding accommodations. If this applies to the above-mentioned student, we will contact you. Thank you.

Please provided the following personal information and attach any additional information which may be helpful in determining eligibility accommodations. Thank you.

Print Name: _____

Title: _____

Area of Specialty: _____

License Number: _____

Address:

_____
_____
_____

Telephone _____ Fax _____

Signature _____ Date _____