



Physical Disability Provider Information

Dear _____

You are being asked to provide documentation of disability for your client, _____. Please fill out the form below and attach the appropriate supplemental documentation. Thank you in advance for your support and cooperation in this matter.

Practitioner Name/Title _____ Date _____

Address _____

License or Certification number _____

Specialty /qualification to make diagnosis _____

To be eligible for services, your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. "Major life activities" are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, reproduction, and working.

1. Nature of disability (Formal Diagnosis). Please include expected duration:

2. Severity of condition. (Mild, Moderate, Severe, etc.)

3. Check all relevant functional limitations, which are **substantially limited**.

___ Walking ___ Hearing ___ Seeing ___ Working ___ Sleeping ___ Caring for self

___ Interacting with others ___ Learning (including memory/concentration)

___ Performing manual tasks ___ other _____

