



### 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, the Americans with Disabilities Act of 1990, and the Americans with Disabilities Amendments Act of 2008. 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 \_\_\_\_\_

4. Please explain how each functional limitation will specifically affect your client in the academic environment.

5. Please suggest reasonable accommodations. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.
  
6. Please state alternatives to meet the documented need if the first request cannot be met.
  
7. Please discuss the impact on your client's disability if the accommodation cannot be granted.
  
8. Is there a current medication treatment plan? yes \_\_\_\_ no \_\_\_\_ n/a \_\_\_\_
9. List current medications: \_\_\_\_\_  
\_\_\_\_\_
10. Special considerations, e.g. medication side effects \_\_\_\_\_  
\_\_\_\_\_
11. Recommended re-evaluation time period or date \_\_\_\_\_
12. Additional comments:

**Please note that all decisions on which reasonable accommodations will be granted will be made by Plymouth Academic Support Services.**

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Signature of Provider, Title, and Credentials

Date

**Please return the completed form and supplemental documentation to:  
Plymouth State University  
Plymouth Academic Support Services  
MSC #9  
Plymouth, NH 03264  
(603) 535-2277 (fax)**

Plymouth State University is committed to providing appropriate accommodations and services to students with disabilities under Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Americans with Disabilities Amendments Act of 2008.

**\* Reviewed by USNH Counsel 3/02**