THE UNIVERSITY of NORTH TEXAS HEALTH SCIENCE CENTER at FORT WORTH

STUDENT PHYSICAL/SYSTEMIC DISABILITY DOCUMENTATION FORM

NOTE: THIS IS ONLY TO BE USED TO DOCUMENT PHYSICAL OR SYSTEMIC DISABILITIES. THIS FORM WILL NOT BE ACCEPTED AS DOCUMENTATION OF ADD/ADHD, LEARNING DISABILITIES OR PSYCHIATRIC CONDITIONS.

This box to be completed and signed by the student.

Student Name: _____ Student ID: _____

Phone Number: _____ UNTHSC Email: _____

Program: _____ Graduation Year if Applicable: _____

I understand that I am requesting my practitioner to provide complete and confidential information regarding my diagnosis. I also understand that completion of this form by a qualified practitioner does not guarantee accommodations.

Student Signature: _____ Date: _____

The above named student has requested accommodations based upon a physical disability at the University of North Texas Health Science Center (UNT Health Science Center). In order to determine eligibility, the UNT Health Science Center ODA Office requires documentation from the appropriate health care professional (e.g. Medical Doctor, Nurse Practitioner, Physical or Occupational Therapist, etc) *who is not a family member of the student*. This documentation will be used to determine if the student's health condition rises to the level of disability as defined by the Americans with Disabilities Act of 1990 and the Rehab Act of 1973 and is therefore protected against discrimination. The health condition must represent a SUBSTANTIAL impediment to major life activities.

Please answer the following questions as completely as possible to maximize the student's chances of qualifying for accommodations. Feel free to write on the back of the form if you need additional space.

Office of Disability Access
Student Service Center (260)
3500 Camp Bowie Blvd, Fort Worth, TX 76107
817-735-2134 Fax: 855-604-0915
www.unthsc.edu/ODA

MAJOR LIFE ACTIVITY ASSESSMENT:

Please Circle the level of limitation created by the student's diagnosis(es) and if you circle anything other than no limitation, please describe specifically how the limitation can impact the student in the educational setting e.g. taking notes, studying, completing tests on time, reading, navigating the campus, attending class or any other typical components of college life.

SPEAKING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

HEARING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

SEEING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

WALKING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

BREATHING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

STANDING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

LIFTING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

SITTING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

PERFORMING MANUAL TASKS (DEXTERITY)

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

WRITING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

SLEEPING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

CONCENTRATION

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

MEMORY

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

READING

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

CARING FOR SELF

Circle one: No Limitation Mild Moderate Substantial

Describe academic impact of limitations:

_____

_____

OTHER

Circle one: No Limitation Mild Moderate Substantial

Describe additional limitations and academic impact of limitations:

_____

_____

ADDITIONAL INFORMATION

1) Is the student currently under your care?

   Yes/No (circle one) Length of Care: _____

2) What is the current diagnosis(es)? Please use ICD 10 codes:

   _____

   _____

3) When did you last examine the student? _____

4) Are the limitations described above permanent, if not how long will they be present?

   _____

   _____

5) List medications which the student is taking and please describe any problematic side effects:

   _____

   _____

   _____

   _____

6) List any regular treatments the student may be undergoing (chemotherapy, dialysis) and describe how this may create difficulties for the student.

_____

_____

_____

HEALTH CARE PROFESSIONAL INFORMATION

Full Name of Health Care Professional: _____

License Number: _____

Signature: _____ Date _____

Health Care Professional Address:

Street _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____