Dear Health Care Provider:

One of your patients has requested a medical accommodation at St. John Fisher College. The Health & Wellness Center will review the medical information you provide and make a recommendation to the designated College representatives for appropriate medical accommodations based on the diagnosed disability. The documentation provided regarding the diagnosed disability must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. **The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.** In addition, in order for a student to be considered eligible to receive an accommodation, the documentation must show functional limitations that impact the individual in a residential setting.

Current and comprehensive documentation is required in order to determine appropriate services and accommodations. The information below outlines what is needed to evaluate eligibility for medical accommodations.

Supporting information form is to be completed by health care providers. Disability forms cannot be completed by a relative or friend of the student or his/her family requesting the accommodation.

- **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. **The health care provider should attach any reports which provide additional related information.**
- **After completing and signing this form, including the Health Care Provider Information Section on the last page, please fax to 585-385-8299 or mail to the Health & Wellness Center at the address below.** The information you provide will *not* become part of the student's educational records, but it will be kept in the student's medical file, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information that would be relevant to assist us in making a determination for a medical accommodation.
- When the documentation is received by the Health & Wellness Center, the student will receive email notification.
- Once completed documentation is received, the Disability Review Committee will review the request. After a decision is determined, a letter or email will be sent to the student outlining what non-academic accommodation(s) (if any) will be made. **Documentation for the request must be received by the Health & Wellness Center by the established deadline:**
  - Requests for housing accommodations and supporting documentation for **new students** must be received by the housing application deadline.
  - Requests for housing accommodations and supporting documentation for **returning students** must be received by January 30th for the following fall semester.

Note on Single Rooms and Private Bathrooms:

While a request for a single room will be reviewed; however, **the provision of a single-room as an accommodation is not common**. A single room does not guarantee privacy or a quiet environment. Students who need to study in a quiet environment can utilize quiet spaces on campus such as rooms in the library. A single room also does not guarantee an allergen-free environment. A single room will not prevent a student from having to interact and negotiate living arrangements with other students, such as alone time, sleep patterns, and study schedules. In community bathrooms, there are several toilets within the bathroom that are for shared use of the residents on the floor, as well as a private toilet.

If you have questions regarding this form, please call the Health & Wellness Center at 585-385-8280.

Thank you for your assistance.

The Health and Wellness Center at St. John Fisher College

Health & Wellness Center ◆ 3690 East Avenue ◆ Rochester, NY 14618 ◆ 585-385-8280 ◆ Fax 585-385-8299

St. John Fisher College Medical Disability Supporting Information Form

STUDENT INFORMATION

(Please Print Legibly)

Name (Last, First, Middle): ____
Date of Birth: ____________________ SJFC Student ID #: @ __________________
Phone (best # to contact student): _________________________________
Address: ____
City/State/Zip: ____
E-Mail address: ____

DIAGNOSTIC INFORMATION

(Please Print Legibly)

This form must be completed by a licensed health care provider qualified to do so (e.g. member of a medical specialty, medical doctor, mid-level practitioner).

1. What is the diagnosis, date of initial diagnosis, and last contact with the student for this diagnosis?
   Diagnosis: ____
   Date of initial diagnosis: ____
   Date of last contact with student for this diagnosis: __________________________________

2. Is the student currently under your care? □ Yes □ No
   If yes, how often do you see this student? ____

3. What is the expected duration of this disability?
   ____
   ____

4. List current medications(s), dosages, impact, and adverse side effects.
   Is the student compliant with the medication (s)? □ Yes □ No
   ____
   ____
   ____
   ____

5. Describe the medical treatment plan; please indicate how the treatment might affect the student's ability to live in residential housing.
   ____
   ____
   ____
   ____

6. What is the severity of the disorder? □ Mild □ Moderate □ Severe

St. John Fisher College Medical Disability Supporting Information Form

7. Major Life Activities Assessment

Please indicate the number that best reflects the degree that the following life activities are affected.

Life Activity	0 – None	1-3 Mild	4-7 Moderate	8-10 Severe
Caring for self				
Talking				
Hearing				
Walking				
Breathing				
Standing				
Reaching				
Lifting				
Sitting				
Seeing				
Sleeping				
Eating				
Toileting				
Performing manual tasks				
Other:				
Other:				
Other:				

8. Describe the functional limitations that are a result of the medical condition, and list recommendations and rationale for the accommodations that you are requesting:

Functional Limitation: ______________________________
____
____
____

Recommendation for Accommodation: ______________________________
____
____
____

9. Describe any situations or environmental conditions that might lead to an exacerbation of the condition

____
____
____

10. Describe the steps that the student has taken (or will take) to personally address her/his needs: (Example of steps to help control asthma: using portable air purification system, using dust-mite proof pillow and mattress casings.)

____
____
____

HEALTH CARE PROVIDER INFORMATION

St. John Fisher College Medical Disability Supporting Information Form

Please fill in completely, sign and date

Provider Name (Print): ____

Title: ____

License/Certification #: ______________________________

Address: ____

____

____

Phone Number: ______________________________

Fax Number: ______________________________

Provider Signature: ____________________________________ Date: ____________

6/2009……Adapted from the Ohio State University Disability Services Forms
7/2010…....Revised
5/201……Revised