SACRAMENTO STATE

California State University, Sacramento
Disability Access Center
6000 J Street • Lassen Hall, Room 1008 • MS 6042 • Sacramento, CA 95819
T (916) 278-6955 • F (916) 278-7825 • www.csus.edu/dac

Medical Provider Form

Instructions: Students applying for academic accommodations at Sac State should complete Section 1 and provide this form to their current qualified medical provider. The qualified medical provider should complete Section 2.
The completed form should be submitted to dac@csus.edu

The student named below may be eligible for services offered through the Disability Access Center. To provide these services, we need information about the student's functional limitations and their impact on the learning environment. Please be assured that the information provided below will be used in confidence for the educational benefit of the student. The Disability Access Center reserves the right to make the final determination concerning the eligibility and continuation of services.

Section 1

NAME:_____ DOB:_____ SAC STATE ID: _____

I authorize_____(my medical provider and/or Medical Records Dept.) to release the requested health information and additional clarification relevant to the impact of my disability on my education.

_____ _____
Student Signature Date

Section 2

THE FOLLOWING IS TO BE COMPLETED BY A QUALIFIED MEDICAL PROFESSIONAL

Date of Initial Patient/Client Relationship:_____
Date of last office visit prior to completing this form: _____

1. Please list any medical conditions that you diagnosed associated with the need for academic accommodations:

Diagnosis	Date of Diagnosis	Severity of Functional Limitation (circle one)			Permanent or Temporary	Date of Last Treatment
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		
		Mild	Moderate	Severe		

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2. What assessments or instruments were used to make the determination of the student's diagnosis(es)?

3. For any diagnosis(es) where you indicated the functional limitation as "severe," please answer the following:

   What is significant about the student's condition that severely impacts their functioning and how was the severity determined?

4. Please list any medications that you have prescribed:

MEDICATION/AUXILIARY AID	FREQUENCY	SIDE EFFECTS

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5. What major life activities are affected by the student's condition (e.g., walking, concentrating, lifting, etc.)?

6. Describe the functional limitation(s) the student self-reported.

7. Describe the functional limitation(s) that you have observed.

Please indicate the following information as applicable to any diagnosis(es) described above

Mobility:

☐ Walking limitations:_____minutes ☐ Standing limitations:_____minutes

☐ Sitting limitations:_____minutes ☐ Stair limitations:_____flights

Fine Motor Skill Functioning:

Dominant hand? ☐Right ☐Left Limitations with both hands? _____

☐ Handwriting limitations:_____minutes ☐ Typing limitations:_____minutes

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Classroom Functioning:

☐ Frequent and/or unpredictable need for restroom use ☐Need for access to food/water during class / testing

☐Need for access to medical supplies during class / testing ☐Breaks for attending to medical needs

Does the student's condition affect their ability to attend class regularly? If so, please provide details as to the symptoms and functional limitations impact on the student's ability to attend class meetings:

Please include any additional comments or information that may further enhance our ability to determine the student's accommodation needs:

Information about Clinician / Medical Provider

Name:
Specialty:
Licensure Type:
License Number:
State issued:
Expiration Date:

By completing and signing this form, I certify that all information provided is correct and true, and that I am not a relative or engaged in any relationship with this client/student that would constitute a conflict of interest associated with my completion of this form. Please return this form directly to dac@csus.edu.

Signature: _____

Date: _____