



SACRAMENTO STATE

California State University, Sacramento
Services to Students with Disabilities
6000 J Street • Lassen Hall, Room 1008 • MS 6042 • Sacramento, CA 95819
T (916) 278-6955 • F (916) 278-7825 • www.csus.edu/sswd

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 sswd@csus.edu.

The student named below may be eligible for services offered through Services to Students with Disabilities. 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. Services to Students with Disabilities 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:

Table with 5 columns: Diagnosis, Date of Diagnosis, Severity of Functional Limitation (Mild, Moderate, Severe), Permanent or Temporary, Date of Last Treatment.



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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 [sswd@csus.edu](mailto:sswd@csus.edu).

Signature \_\_\_\_\_

Date \_\_\_\_\_