THE UNIVERSITY OF SCRANTON

CTLE

CENTER FOR TEACHING & LEARNING EXCELLENCE

PART I: COMPLETED BY STUDENT

Medical Provider Documentation

Introduction: The below named student has indicated that you are the (physician, psychiatrist, social worker, and/or licensed counselor) who can provide information to determine the student's eligibility for necessary, reasonable and appropriate accommodations. We ask that you provide current and comprehensive information attesting to the student's disability and documenting the functional impact of the disability. The information you provide will not become part of the student's educational records but will be kept in the student's confidential file in CTLE.

Student's Name: _____ _____ _____
(Last) **(First)** **(Middle)**

ROYAL ID: _____ **Cell Number:** _____

Email: _____

PART II: COMPLETED BY MEDICAL PROVIDER

Please respond to the following items regarding the above named student:
(Note: A person with a disability is defined as someone who has "a physical or mental impairment that substantially limits one or more major life activities.")

1. What is the nature of the student's disability?
   _____
   _____
   _____

2. How is the student substantially limited by this disability?
   _____
   _____
   _____

3. What reasonable accommodations will the student require?
   _____
   _____
   _____

Thank you for taking the time to complete this form.

Name/Title: _____

Address: _____

Phone: _____

License #: _____ Date: _____

Signature of Provider: _____

By typing your full name you are thereby signing this form.

Please Note: The provider completing this form cannot be a relative of the student.
Please attach medical information needed to substantiate a disability and the need for accommodations (i.e. current medical records, additional copies of test results, etc.)

Please email the completed form to disabilityservices@scranton.edu or return (email) it to the student so it can be uploaded to the Accommodate system.