THE UNIVERSITY OF SCRANTON

CTLE

CENTER FOR TEACHING & LEARNING EXCELLENCE

MEDICAL PROVIDER DOCUMENTATION

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.

Please take into consideration when completing this form:

1. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting may delay the eligibility review process by necessitating follow up contact for clarification.
2. Healthcare provider should attach any reports which provide additional related information. If a comprehensive diagnosis report is available that provides the requested information, copies of that report can be submitted for documentation as well.
3. The provider completing this form cannot be a relative of the student.

Information about the Student's Disability (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.")

Student's Name: _____ _____

Royal ID: _____ Cell Number: (____) _____

EMAIL _____

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 your help in providing this information so that we may begin providing services as soon as possible. Please return this form to disabilityservices@scranton.edu or to CTLE, University of Scranton, 800 Linden Street, Scranton, PA 18510.

Physician's signature: _____

Printed name and title:
_____

Office address: _____

Office telephone: _____ Date: _____

Please attach any relevant medical information.