Disability Resources
Request for Accommodations (Medical Provider Form)

ILLINOIS COLLEGE
CENTER FOR ACADEMIC EXCELLENCE

Student Name: _____ **DOB:** _____

INTRODUCTION

Illinois College is required by Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (1990), and the Americans with Disabilities Amendment Act (2008) to provide accommodations that are needed for equitable access to the College's programs and services.

Federal law defines a disability as a "physical or mental impairment which substantially limits one or more major life activities." Examples of major life activities are walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. Major life activities also include major bodily functions, such as the immune system, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. It is important to note that any diagnosed condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" a major life activity.

Illinois College Disability Resources strives to provide accommodations for qualified students. By law, Disability Resources is not required to modify requirements that are essential to the course or program or to provide accommodations for persons whose impairments do not substantially limit one or more major life activities. To determine eligibility for an accommodation, relevant and comprehensive documentation or verification from the diagnosing physician, psychiatrist, psychologist, or other qualified healthcare professional may be required. The healthcare professional must be an impartial evaluator who is not a family member nor in a dual relationship with the student.

ALL QUESTIONS BELOW MUST BE COMPLETED BY A QUALIFIED HEALTHCARE PROVIDER

Note to Providers: This assessment should be current, include a clearly stated diagnosis, and must provide information about how the diagnosis substantially limits one or more major life functions, including those expected for a post-secondary experience.

1. Specific diagnosis(es): _____

2. Date of diagnosis(es): _____

3. Date of most recent office visit/appointment: _____

4. Current medications: _____

5. Treatment plan and/or medications (including frequency and dosage) currently prescribed or used to minimize the impact of the disability:

6. Side effects of prescribed medication that may affect cognitive ability and/or academic success:

7. Nature, frequency, and severity of symptoms of the student's condition or disability:

8. What is the expected duration of the condition or disability?

_____ Long term: 3-12 months or longer

_____ Short term: 60-90 days

_____ Temporary: less than 60 days

Please explain:

9. Describe the symptoms the student presently displays:

10. Does the diagnosed condition rise to the level of a disability (according to the definition on page 1)?

_____ Yes _____ No

If yes, please explain the current functional limitations imposed by the condition. Indicate how the disability interferes with or limits any facet of a major life activity, including current participation in courses, programs, and campus life (residential housing and dining services). Include the impact of medication or other treatments.

11. Provide recommendations for specific accommodations to address the functional limitations indicated in the previous question. Include a clear rationale between key components of the diagnosed condition and the accommodation requested and any past accommodations and their effectiveness.

_____

_____

_____

_____

12. What parts of the student's academic, social, or campus experience will the student be unable to access without your recommended accommodations?

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

I verify that the above-named student information is correct, the student is a patient or client that I have been treating, and I am not in a dual relationship with the student (relative, friend, etc.).

Healthcare Provider Name: _____

Agency/Institution: _____

Address: _____

Telephone Number (with area code): _____

Healthcare Provider Signature: _____ Date: _____

Please return this form and any applicable documentation to:

Anna Anderson, Disability Resource Coordinator

disability.resources@ic.edu (preferred)

1101 West College Avenue, Jacksonville, IL 62650

(217) 245-3221