



## Physician Documentation Form

Dear Medical/Clinical Provider:

The below-named student has requested accommodations from the office of Student Services - Disability, Access, and Inclusion at Richard Medical Academy. To determine eligibility and provide accommodations, we will need your assessment, diagnostic impressions, and recommendations.

Under the Americans with Disabilities Act (Amendments Act) of 1990 (2008) and Section 504 of the Rehabilitation Act of 1973, otherwise qualified individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is protected under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities with an expected duration of no less than six to eight weeks.

All contact information and documentation provided to this office is kept secure, accessible only to RMA personnel with a need for access, in accordance with FERPA and HIPAA statutes and regulations. Information concerning accommodations or documentation will not be released or discussed without written consent from the student.

***All sections of this form must be completed*** and returned as soon as possible so that we may verify eligibility. Providers may also use their own format as long as the requested information is included.

Thank you in advance for your time and support.

Student's Name: \_\_\_\_\_

Date of Request: \_\_\_\_\_

## Student Information - Completed by the Provider ONLY

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Diagnostic Information

Primary Diagnosis \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

How was the diagnosis made? (please check all applicable answers)

- |                                                                |                                                          |
|----------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Interviews with the person themselves | <input type="checkbox"/> Testing (please enclose a copy) |
| <input type="checkbox"/> Interviews with other persons         | <input type="checkbox"/> Neuro-Psychological Testing     |
| <input type="checkbox"/> Behavioral Observations               | <input type="checkbox"/> Educational Testing             |
| <input type="checkbox"/> Developmental History                 | <input type="checkbox"/> Psychological Testing           |
| <input type="checkbox"/> Educational History                   | <input type="checkbox"/> Other (please specify)          |

Please indicate the **impact** on major life activities below

Life Activity	Negligible	Moderate	Substantial	Not Sure
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading Fluency/ Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking and Processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management/ Self Regulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Please describe specific functional limitations in the context of an educational environment.

In the classroom environment	
In the testing environment	
Assignment completion (please note that we rarely approve accommodations for assignment extensions as keeping pace is a requirement for program completion).	
Expressive and receptive verbal and written communication	
In an applied setting, such as a lab or clinical placement in hospital or long term care	

**Medically Necessary Accommodations**

Please include medically necessary accommodations based on identified limitations above.

**Certifying Medical Professional**

Signature of Medical Professional	Date
Printed Name and Title	License #
Address	Phone #