Health Care Provider

Health Care Provider

7. Are there any unusual circumstances surrounding this condition that would help us make an appropriate decision regarding accommoations for this student?

_____

_____

_____

Please attach any additional information you feel will be helpful to us in assisting the student with his/her request for consideration of modification to housing or dining options.

Signature of Professional/Provider _____ Date _____

License # _____ State _____

Please Type/Print the Following:

Name/Title: _____

Address: _____

_____

Telephone ( )_____ Fax ( ) _____

A staff member of the Accessibility Resources Center, Health Services or Counseling & Psychological Services may need to contact you for clarification purposes. Please list the best times to contact you:

_____

This document may not be released without written permission from the student, except in cases of disclosure as required/allowed by FERPA. It will be destroyed seven years after the student is no longer enrolled. FERPA allows the student access to this document, and copies of this document, but you may specify that this access be given only after meeting with a person qualified to explain the document.

Check ONE: _____ Student Access
_____ Student Access Only after meeting with qualified professional

Office Use Only

☐ Approved ☐ Denied Date_____ Date Student Notified_____

☐ Tabled for further documentation Date_____ Date Student Notified_____

Comments: _____

_____

ARC Signature: _____

☐ Appeal Approved ☐ Appeal Denied Date_____ Date Student Notified_____

DOS Signature: _____