UND STUDENT DISABILITY RESOURCES HEALTHCARE PROVIDER FORM

Purpose of this Form

At the University of North Dakota Student Disability Resources approves academic and housing accommodations for students who participate in a interactive process with our office. Information provided on this form is only used to assist in determining if this student's physical or mental health condition is a disability and what accommodations may be appropriate.

The information provided to UND Student Disability Resources on this form is protected by FERPA.

To learn more about FERPA please visit https://und.edu/academics/registrar/ferpa.html

Instructions

Please legibly and thoroughly discuss the educational and/or housing effects of the stated disabilities in this form. This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated condition(s).

How to Submit

Once this form has been completed it should be submitted to UND Student Disability Resources. The student may upload documentation through the application portal. The student or medical professional/provider may send via email, fax, or mail. Contact information is provided below.

Student Disability Resources
University of North Dakota
221 Centennial Dr Stop 8006
Grand Forks, ND 58202-8006

Phone: 701.777.2100
Fax: 701.777.2100
Email: UND.sdr@UND.edu

STUDENT INFORMATION

(UND Student Completes this Section)

Student Name: _____ **Student ID Number:** _____

Phone: _____ **Email:** _____ **Date of Birth:** _____

HEALTHCARE PROVIDER INFORMATION

(Health Care Professional Completes this Section)

Provider Name: _____

Credentials and Licensing Information: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

DISABILTY ASSESSMENT

(Health Care Professional Completes this Section)

1. **What is the specific diagnosis/health condition? Please also provide the relevant DSM-V or ICD code.**

_____

2. **When was the diagnosis(es) made?** _____
3. **When did you last see the student?** _____
4. **Do the symptoms of the diagnosis(es) need to be reevaluated on a regular basis? If yes, how often?**

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5. **Please describe the current symptoms of the stated diagnosis(es) this student experiences. Example: Student's dominant wrist is immobilized**

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6. **If the student experiences episodic flare-ups of their condition please describe any triggers of episodes, the frequency and duration of episodes, and care plan for management/recovery of the episode.**

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7. **How does the diagnosis(es) significantly affect the student's performance in academic settings?**

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8. **How does the medication and/or treatment plan significantly affect the student's performance in academic settings?**

By signing below, I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature: _____

Date: _____

If the student needs mobility or housing related accommodations, please fill out the "Mobility Assessment" and/or "Housing Assessment" pages below.

MOBILITY ASSESSMENT SUPPLEMENT

(Complete only for conditions affecting student's ability to access physical spaces)

1. **(A) Is the student able to climb or descend stairs? (check one)**

   ◯ Yes
   ◯ Yes, with limitations.
   ◯ No

1. **(B) Does the student have difficulty walking? If so, please elaborate on limitations, the distance they are able to transport themselves, etc.**

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2. **Does the student use any assistive mobility devices (e.g. wheelchair, crutches, cane, etc.), personal attendant, or service animal? If so, please list all applicable.**

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3. **Does the student have a current need for ergonomic or facility modifications (e.g. adjustable desk, adjustable chair, sit/stand desk, podium, grab bars (shower/toilet)).**

By signing below, I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature: _____

Date: _____

HOUSING ASSESSMENT SUPPLEMENT

(Healthcare Professional Completes This Section. Complete only for conditions affecting the student's living)

1. **How does the diagnosis(es) significantly affect the student's access in the living environment?**

By signing below, I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature: _____

Date: _____