NOTRE DAME DE NAMUR UNIVERSITY

Disability Resource Center (DRC)

Medical Provider Form

To be filled out by the medical provider

I. Student

Name: Last ____________________________First____________________________ Date of Birth __________________________
Home Phone _______________________ Cell Phone____________________ E-mail ____
Address____

II. Certifying Professional

Name____
Professional Title _________________________________Highest Degree____
Phone____ E-mail____
Address____
License/certification, number, and state: ____

III. Condition:

a. Date of first contact: ____________ Date of last contact: _____________
b. Please list relevant diagnosis(es):

Diagnosis(es)	Does this condition substantially limit a major life activity (yes, no, when active)?	Would you rate the disability/condition as being mild, moderate or severe?	Is the condition stable, variable, or progressive?

IV. <u>NOTE: THIS SECTION MUST BE THOROUGHLY COMPLETED BY THE TREATING PHYSICIAN OR IT WILL BE RETURNED TO THE STUDENT FOR RESUBMISSION. AS A RESULT, ACCOMMODATIONS MAY BE DELAYED.</u>

a. How will the limitations of the “disability/condition” affect the student’s ability to function?

b. What conditions will cause the disability to manifest itself with greater intensity?

c. Please make *specific recommendations* for accommodations that this student should receive to have equal, appropriate and reasonable access to services and programs. (Please use the back of this form if additional space is needed.)

Signature: ____ Date: __________________

Please return the form to: Notre Dame de Namur University | DRC | 1500 Ralston Ave.| Belmont, CA 94002