Indiana State University

Accommodation Provider Documentation Form

1. Student Requesting Accommodations

Name: _____ Student ID: _____

Contact Phone Number: _____ Date of Birth (MM/DD/YYYY): _____

2. Authorization of Release of Information (REQUIRED)

By signing below, I authorize Indiana State University Accessibility Resource Office to receive documentation and information, relevant to my request for a housing or academic accommodation, from my provider who I have listed below. I also authorize my provider to discuss my condition(s) and the documentation and information provided with the appropriate Indiana State University personnel on an as-needed basis. This information is kept confidential. Typing name and date into the form constitutes an electronic signature.

Provider Name: _____ Provider Phone Number: _____

Provider Address: _____

Provider City: _____ Provider State: _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian signature is only required if student is under 18 when the document is submitted

3. Information for Provider

The above named student has requested special consideration for academic and/or housing accommodations for a disability or medical need at Indiana State University. The Accessibility Resource Office is attempting to determine whether this student has a condition or combination of conditions that merits reasonable accommodations for classwork or residential living. Current and comprehensive documentation will assist the Accessibility Resource Office in understanding how the disability or condition impacts the student in on-campus housing and the current impact of the condition(s) as it relates to the housing request.

Documentation and all relevant information must be completed or provided by an appropriately qualified licensed clinical professional or healthcare provider who has seen the student in-person in the past twelve months and is familiar with the history and functional limitations of the student's condition(s). Documentation completed by a family member is not acceptable. All documentation will be evaluated on a case-by-case basis.

Please attach any additional sheets, other information, evaluations, etc. which are relevant to the student's current condition and supports the student's request for a housing accommodation at Indiana State University.

PLEASE INDICATE WHAT REASONABLE ACCOMMODATIONS WILL ENABLE THE STUDENT LISTED ABOVE TO LIVE IN ON-CAMPUS HOUSING AND TO SUCCEED ACADEMICALLY AT INDIANA STATE UNIVERSITY.

4. Provider should completely respond to the following:

A. How long has the student been under your care and when was the last time you saw the student?

B. What is the diagnosis(es) or condition(s) that impact the student's physical and/or cognitive function? You must state the ***SPECIFIC*** diagnosis(es), terms such as "suggests" or "is indicative of" are not acceptable.

4. Provider should completely respond to the following: (continued)

C. What is the evidence supporting the diagnosis(es)? Please provide a copy of any test results supporting the diagnosis(es) or other information used to reach the diagnosis(es).

D. How long has the student experienced this condition(s) and what is the expected duration?

E. What is the impact of the condition(s) in the virtual and/or physical classroom and/or living environment? Does the condition(s) significantly limit any major activities and what is the severity of any limitations (mild/moderate/severe)? Please explain.

F. Considering the mental and physical requirements of being a student at ISU, and living in on-campus housing, what recommendations for accommodations or services do you have to address the functional impact(s) and limitation(s) you have specified above? How would these accommodations **directly reduce or alleviate** the condition(s), impact(s) and limitation(s) noted above?

G. Is there any other information you would like to add that might be helpful to us in working with this student?

5. Provider Signature

Print Name: _____ Title: _____

License or Certification: _____ State: _____

Provider Signature: _____ Date: _____

Date Received:	**Received by:**

Contact The Accessibility Resource Office with questions at isu-dss@indstate.edu or call the office coordinator at 812-237-7920