Susquehanna University
Services for Students with Disabilities Office
Documentation for Disability/Medical Condition
MEDICAL PROVIDER FORM

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. 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!

a. How will the limitations of the "disability/condition" affect the student's ability to function?

b. What conditions will cause the disability manifest?

c. Please make *specific recommendations* for accommodations this student will require to have equal, appropriate and reasonable access to services and programs.

Signature: _____ Date: _____

Please return to Director of Disability Services, Susquehanna University, 514 University Ave, Selinsgrove, PA 17870 or FAX to 570-372-2781.