Medical Provider Verification

Dear Health Care Professional,

One of your patients is a student at Lone Star College requesting a disability-based academic accommodation. Accommodations are made for qualified students with a disability in order for them to equally participate in all programs and services offered by the College to ensure compliance with all applicable disability laws. In order for the Disability Services Office to determine the student's accommodation eligibility, we need your clinical assessment/diagnosis of the student. You may fax us a copy, but our records must include an original with your signature and business card. In addition to the form provided, you may provide supplemental information on your letterhead.

In order for the student to be certified as eligible, the documentation must show how the disability substantially limits one or more major life activities. Current and relevant information is required in order to determine the appropriate reasonable accommodation that may be offered to the student.

All information should be completed by a health care professional qualified to diagnose and treat the student's disability.

Please provide the following:

1. A completed and signed Provider Verification packet for each disability and
2. Staple your business card to each Provider Verification packet.

The information you provide will be kept confidential in accordance to the Family Education Rights and Privacy Act (FERPA) and may be released to the student upon his/her written request for records.

If you have any questions regarding this form or opportunities for the student, please contact Disability Services at the information listed below. We may also contact you directly for supplemental information if necessary to make a determination

Thank you for your assistance,

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*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, **we are asking that you not provide any genetic information when responding to this request for medical information**. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought of received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider Verification of Physical/Medical Disability

Student Name: _____ Student ID: _____

To the Student: **The form below the line must be completed by your medical provider** who is qualified to diagnose and treat your disability. The Disability Services Office reserves the right to request additional documentation or contact your provider for additional information. If this form is completed by anyone other than a qualified licensed profession, the information will not be used to support your accommodation request. Inaccurate and incomplete documentation may result in a delay of your evaluation. *Please note that this form may not be used as documentation for a learning disability or ADD/ADHD.*

Please sign the box below to give your medical provider authorization to release information to the Disability Services Office.

I, _____, authorize my medical provider to release to Lone
Printed Student Name
Star College's Disability Services Office the medical information requested on this form for the purpose of determining appropriate accommodations for my disability while a student at Lone Star College.

Patient Signature: _____ Date: _____
Student Signature

TO BE COMPLETED BY THE MEDICAL PROVIDER

Is the student currently under your care? ☐ No ☐ Yes If yes, for how long? _____

_____

What is the diagnosis/impairment/condition? (Please describe and use ICD 10 diagnostic codes)

_____

_____

_____

_____

_____

Date(s) of Onset: _____

A. FUNCTIONAL LIMITATION CHART

Reminder: Please identify functional limitations without regard for mitigating measures (i.e., medications). For intermittent conditions, assess functional limitations based on a picture when all symptoms are active. Use an "X" to indicate level of impact on major life activities.

Major Life Activities	No Impact	Moderately Impacts	Substantially Impacts	Unknown
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Sitting				
Other:				

What are the specific functional limitations resulting from the disability's impact on the major life activities in a learning environment (e.g. unable to handle stairs, miss class due to side effects from disability or medication, unable to sit for long periods of time)? _____

_____

_____

Are the functional limitations permanent? ☐ No ☐ Yes If no, what is the anticipated date of resolution? _____

_____

Is the student currently undergoing treatment? ☐ No ☐ Yes If yes, please describe the type of treatment and list any medications and possible side effects that may affect the student in an academic setting: _____

_____

_____

_____

B. FUNCTIONAL OR BEHAVIORAL PRESENTATION CHART

Please use an "X" to indicate additional limitations or behavioral manifestations.

Limitations and Behavioral Manifestations	**Not an Issue**	**Moderate Issue**	**Substantial Issue**	**Unknown**
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

What are the specific behavioral limitations resulting from the disability's impact on the major life activities in a learning environment? _____

_____

_____

Are the behavioral limitations permanent? ☐ No ☐ Yes If no, what is the anticipated date of resolution? _____

_____

Is the student currently undergoing treatment? ☐ No ☐ Yes If yes, please describe the type of treatment and list any medications and possible side effects that may affect the student in an academic setting: _____

_____

_____

_____

Medical Provider Information:

First Name: _____ Last Name: _____

Title: _____ State License Number: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Fax: _____

Physician/Provider Signature: _____ Date: _____

PLEASE ATTACH BUSINESS CARD HERE