Office of Accessibility Services

Accommodation Request Medical Certification

This form (or a similar letter addressing the requested information) must be completed and signed by the treating health care provider when a student needs an accommodation related to their education as a result of a disability. Documentation should be faxed to the Office of Accessibility Services at 937.328.7969. The information provided will help us determine eligibility for reasonable accommodations.

SECTION 1: COMPLETED BY STUDENT

Student Name: _____ Student ID #: _____

Major: _____

SECTION 2: COMPLETED BY THE HEALTH CARE PROVIDER

1. Please describe the nature and severity of your patient's medical condition, including relevant medical facts related to the condition. (e.g. symptoms, diagnosis, and regimen of treatment) and functional limitations as it relates to their need for a workplace accommodation. (A reasonable accommodation is a modification or adjustment to a course, program, service, or activity that enables a qualified student with a disability to have an equal opportunity to access and use benefits, privileges and services that are available to similarly-situated students without disabilities.)

2. Do you consider your patient's condition to be a disability? ☐ Yes ☐ No
   (Based on the Americans with Disabilities Act, a disability is defined as a mental or physical condition that substantially limits a major life activity compared to most people. "Substantial" in this context is somewhat subjective, but means that in your professional opinion there is a notable, significant, meaningful limit/difference to the manner in which the individual engages in the activity, the conditions necessary for them to engage in the activity, the duration for which they can engage in the activity, or the frequency which they engage in the activity. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working and the functioning of major bodily systems.)

3. Please describe your recommendations for restrictions, modifications or adjustments to the employee's job duties or work environment and explain how each will address the work-related limitation.

4. Please provide a timeline for these restrictions, modifications or adjustments listed above. If temporary, please provide the estimated end date for the restrictions.

   ☐ Temporary: _____ ☐ Indefinite (expected to last longer than 6 months): _____ ☐ Unknown

5. Additional Comments:

SECTION 3: HEALTHCARE PROVIDERINFORMATION

Health Care Provider's Name / Practice: _____

Fax: _____ Phone: _____

Signature: _____ Date: _____