UNIVERSITY OF NORTH DAKOTA

UND ACCESSIBILITY FOR STUDENTS HEALTHCARE PROVIDER FORM

Purpose of this Form

At the University of North Dakota, Accessibility for Students approves academic and housing accommodations for students. Information provided on this form is only used to assist in determining if this student's physical or mental health condition is a disability and what accommodations may be appropriate.

The information provided to UND Accessibility for Students on this form is protected by FERPA. To learn more about FERPA please visit https://und.edu/academics/registrar/ferpa.html

Instructions

Please legibly and thoroughly discuss the educational and/or housing effects of the stated disabilities in this form. This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated condition(s).

How to Submit

Once this form has been completed it should be submitted to UND Accessibility for Students. The student can upload this form to their application through our application portal or it can be turned into UND Accessibility for Students directly by the student or healthcare provider via the contact information below:

Accessibility for Students
University of North Dakota
2901 University Ave Stop 9040
Grand Forks, ND 58202-9040

Phone: 701.777.2664
Email: UND.accessibilityforstudents@UND.edu
Fax: 701.777.2664

STUDENT INFORMATION (UND Student Completes This Section)		
Name		Phone
Student ID Number	Email	Date of Birth
HEALTHCARE PROVIDER INFORMATION (Healthcare Professional Completes This Section)		
Name:		Credentials and Licensing Information:
Address:		
Phone:	Fax:	Email:

DISABILITY ASSESSMENT
(To be completed by a qualified healthcare provider)

1. What is the specific diagnosis/health condition? Please also provide the relevant DSM-V or ICD code.

2. When was the diagnosis(es) made?

3. When did you last see the student?

4. Do the symptoms of the diagnosis(es) need to be reevaluated on a regular basis? If yes, how often?

5. Please describe the current symptoms of the stated diagnosis(es) this student experiences. *Example: Student's dominant wrist is immobilized.*

6. If the student experiences episodic flare-ups of their condition please describe any triggers of episodes, the frequency and duration of episodes, and care plan for management/recovery of the episode.

DISABILITY ASSESSMENT (CONT.) (To be completed by a qualified healthcare provider)
7. How does the diagnosis(es) significantly affect the student's performance in academic settings?
8. How does the medication and/or treatment plan significantly affect the student's performance in academic settings?

By signing below I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature:_____ Date:_____

If the student needs mobility or housing related accommodations, please fill out the "Mobility Assessment" and "Housing Assessment" pages below.

MOBILITY ASSESSMENT SUPPLEMENT

(Complete only for conditions affecting student's ability to access physical spaces)

9.A. Is the student able to climb or descend stairs? (check one)

- ◯ Yes
- ◯ Yes, with limitations
- ◯ No

9.B. Does the student have difficulty walking? If so, please elaborate on limitations, distance they are able to transport themselves, etc.

10. Does the student use any assistive mobility devices (e.g. wheelchair, crutches, cane, etc.), personal attendant, or service animal? If so, please list all applicable.

11. Does the student have a current need for ergonomic or facility modifications (e.g. adjustable desk, adjustable chair, sit/stand desk, podium, grab bars (shower/toilet).

By signing below I am verifying that the transportation/parking information provided above is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the conditions necessitating the need for transportation/parking accommodations.

Healthcare Provider Signature:_____ **Date:**_____