**College of the Ouachitas**
**Disability Support Services**

# HEALTH CARE PROFESSIONAL FORM

**Student's information**

**Name:**_____

**Address:**_____

_____

**Phone (home):**_____ **Phone (cell):**_____

**INSTRUCTIONS – This form must be completed by a HEALTH CARE PROFESSIONAL**
The above-named student is requesting accommodations at College of the Ouachitas. In order to respond to the student's request, we require that you complete the information below. Please complete this information, attaching additional pages if necessary.
**Please note that this form must be completed prior to receipt of accommodations.**

Professional's Contact Information (Please Print): **Physician's Stamp:**

Name: _____ Address:_____

Telephone #: ( ) _____ _____

Fax #: ( ) _____ _____

License #: _____ _____

Disability type (please check at least one):

Physical_____ Neurological _____ ADHD _____ Psychological _____

**PRINT CLEARLY (if more space is needed, please use office letterhead)**

What is the student's relevant diagnosis/impairment? How long has this student had this diagnosis?

_____

_____

Is the impairment expected to last six months or longer? __ Yes __ NO

Describe the present symptoms, their frequency and severity, and how the disability interferes with one or more major life activities.

_____

_____

_____

_____

_____

What treatment and/or medication(s) is the student undergoing? Please list medications and dosages.

_____

_____

_____

Do you expect these symptoms to continue for the foreseeable future? ____yes ____no
If no, when do you expect the symptoms to abate?

_____

How will the student be able to manage these symptoms in other campus environments (e.g. classrooms, dining hall, library)?

_____

_____

What specific symptoms does the student have that, in your judgment, **prohibit** the student from being able to live safely in a standard on-campus residence hall.

_____

_____

For episodic conditions, how frequent are the episodes, and what is their duration and severity?

_____

_____

_____

What accommodations are reasonable and appropriate (i.e. to maintain general wellness) for a college student?

_____

_____

_____

Are there other effective means that would achieve similar benefits as the requested accommodation?

_____

_____

Is the impact of the condition life threatening if the request is not met? ___ Yes ___ No

___I have attached the documentation with the results of evaluations which led to this diagnosis.

Professional's Signature: _____ Date: _____

Print name: _____

**Please return the completed form to:**
**Student Affairs**
**One College Circle**
**Malvern, AR 72104**
**501-332-0280**
**Fax: 501-337-9382**