Saint Mary's University
ACCESS SERVICES

Documentation Request Form

What is the Policy and Process?

Saint Mary's University provides reasonable accommodations to students with disabilities. Students with diagnosed physical, medical or mental health conditions requiring academic accommodations should complete and return this form, including the section to be completed by your healthcare provider. Diagnostic Reports may be submitted as documentation if they address the areas below.

Documentation should be submitted to:

Office of Access Services
Fax: (507) 457-6660
Winona Campus: accessservices@smumn.edu
SGPP: accessservicessgpp@smumn.edu

To Be Completed by the Student

Name:
Phone:
Email:
Date:

Do you have a medical diagnosis?

What major life activities are substantially limited by this disability?

What specific academic accommodation are you requesting? Please explain how this accommodation will address the limitations described above?

Consent and Release of Information*:

- ☐ I authorize Saint Mary's University and its representatives to share information related to my *Request for Academic Accommodations* with relevant departments and individuals. I recognize that the sharing of this information is necessary for departments to work collaboratively for my benefit.
- ☐ I authorize Saint Mary's University and its representatives to contact my healthcare provider for additional information, related to this request.
- ☐ I have read this document thoroughly and agree to the process described.

*This release is effective from the date signed as long as the student is enrolled at SMU.

_____ _____

Student Signature Date

To Be Completed by the Healthcare Provider

Instructions for Healthcare Provider Completing this Form:

The student named above has requested an academic accommodation at Saint Mary's University of Minnesota.

Saint Mary's University provides reasonable accommodations to students with documented disabilities. In order to effectively evaluate the student's request, the University requests documentation from an appropriately qualified provider.

Please answer each question on the form thoroughly, as this information will be used in determining how to most appropriately address the student's request for accommodations.

Please feel free to contact us with any questions you may have. Completed forms can be returned to the student, or submitted directly to the Office of Access Services.

Winona Campus:

accessservices@smumn.edu

Phone: 507-457-7822

Fax: 507-457-6660

SGPP:

accessservicessgpp@smumn.edu

Phone: 612-238-4576

Fax: 507-457-6660

Healthcare Provider Statement for Academic Accommodations

Student Name: _____ DOB: _____

Major Life Function/Disability Information

Accommodations are available to students identified as having a disability. The above student has requested accommodations through Access Services. To be considered for those services, Saint Mary's University requires appropriate documentation. A disability is defined under the Americans with Disabilities Act as "**a physical or mental impairment that substantially limits one or more major life activities**."

Examples of major life activities include: seeing, hearing, eating, sleeping, walking, standing, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, social-emotional output, and self-care. This is not an exhaustive list.

Based on the above definition, does this individual have a disability? **YES NO**

Medical History

Primary Diagnosis:

Secondary Diagnosis:

(If applicable, attach a copy of evaluation results, pertinent lab work, criteria for diagnosis) When was this condition diagnosed?

How long has the student been under your care?

Date of your most recent evaluation related to this condition? _____

Does the student take prescription medication for this condition? **YES NO**

*****If yes, please specify medications, doses and frequency:

Does the student utilize other treatments or interventions for this condition? **YES NO**

*****If yes, please describe:

The prognosis for the medical condition or disability above is:
Permanent _____ 6-12 months _____ 6 months or less _____ Episodic (please describe below)
_____

If episodic in nature, do you expect this condition to result in intermittent absences from class? If so, please estimate the frequency of absences per month. _____

Additional Information

What major life activities are substantially limited by this disability (functional limitations)? Please describe:

How would this accommodation impact the student's function?

Additional Comments:

Healthcare Provider Name: _____
Signature: _____
License # / State/Credential: _____
Address: _____
Phone: Fax: _____

Medical Office Stamp:

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