**Health Care Practitioner Form  
Disability Diagnosis and Treatment  
Unity at Pineland**

Dear Health Care Practitioner:

You are being asked to provide documentation of disability for your client. Please fill out the form below and attach supplemental documentation. Unity Environmental University is committed to providing reasonable accommodations to qualified students with disabilities. Please assist us in supporting those students who qualify by providing as much information about your diagnosis as possible and by linking your diagnosis with specific treatment recommendations.

To be eligible for services, your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or Title III of the Americans with Disabilities Act (ADA) of 1990 or the ADA Amendments Act of 2008. These laws define a person with a disability as one who has a physical or mental impairment that substantially limits one or more major life activities, has a history record of such impairment, or is regarded as having such an impairment.

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Practitioner Name / Title:** |  | | | **Date:** |  |
|  | **Address:** |  | | | **Phone:** |  |
|  | **:** |  | | | **Fax:** |  |
|  |  |  |  |  |  |  |
|  | **Specialty / qualifications to make diagnosis:** |  | | | | |
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|  |  |  |  |  |  |  |
|  | **Student’s Name:** |  | | | | |
|  |  |  |  |  |  |  |
|  | **Date of Last Appointment:** |  | | | | |
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| **Nature of disability [**formal diagnosis**]. Please include *expected duration* and *severity* of condition [**mild, moderate, severe**]** | | | | | | | |
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| **Check all relevant functional limitations that are limited AND explain how each limitation will specifically affect your client in the academic environment.** | | | | | | | | | | |  | |
|  | | **FUNCTIONAL LIMITATIONS** | **Mild** | **Moderate** | **Substantial** | **Comments** |  | | |  | |
|  | | Caring for oneself |  |  |  |  |  | | |  | |
|  | | Performing manual tasks |  |  |  |  |  | | |  | |
|  | | Seeing |  |  |  |  |  | | |  | |
|  | | Hearing |  |  |  |  |  | | |  | |
|  | | Breathing |  |  |  |  |  | | |  | |
|  | | Sleeping |  |  |  |  |  | | |  | |
|  | | Eating |  |  |  |  |  | | |  | |
|  | | Standing |  |  |  |  |  | | |  | |
|  | | Lifting |  |  |  |  |  | | |  | |
|  | | Bending |  |  |  |  |  | | |  | |
|  | | Walking |  |  |  |  |  | | |  | |
|  | | Speaking |  |  |  |  |  | | |  | |
|  | | Communicating |  |  |  |  |  | | |  | |
|  | | Learning |  |  |  |  |  | | |  | |
|  | | Reading |  |  |  |  |  | | |  | |
|  | | Thinking |  |  |  |  |  | | |  | |
|  | | Concentrating |  |  |  |  |  | | |  | |
|  | | Working |  |  |  |  |  | | |  | |
|  | | Other major bodily functions: |  |  |  |  |  | | |  | |

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| **In the space below, please suggest reasonable accommodation that have not already been addressed. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.** | |  |
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| **Please state alternatives to meet the documented need if the first accommodation request proves to be unduly burdensome on the University.** | |  |
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| **Please discuss the impact on your client’s disability if the accommodation cannot be granted.** | |  | |
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| **Additional comments:** | |  |
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|  |  | |  |  | |  |  |
|  | **Signature of specialist:** |  |  | **Date:** |  |  |  |
|  |  |  |  |  |  |  |  |
| **Please return the completed form and supplemental documentation [**by mail, email as attachment, or fax**] to:** | | | | | | | |
| ADA Accessibility Coordinator  Unity Environmental University at Pineland  70 Farm View Drive, Suite 200  New Gloucester, ME 04260  [PinelandAccessibility@unity.edu](mailto:PinelandAccessibility@unity.edu)  207-509-7380 (phone or fax) | | | | | | | |