THE
UNIVERSITY
OF RHODE ISLAND
DISABILITY, ACCESS
AND INCLUSION

Physician Documentation Form

Dear Medical/Clinical Provider:

The below-named student has requested accommodations from the office of Disability, Access, and Inclusion (DAI) at the University of Rhode Island. To determine eligibility and provide accommodations, we will need your assessment, diagnostic impressions, and recommendations.

Under the Americans with Disabilities Act (Amendments Act) of 1990 (2008) and Section 504 of the Rehabilitation Act of 1973, otherwise qualified individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is protected under the law, documentation must indicate that a *specific disability exists* and that the identified disability *substantially limits one or more major life activities* with an expected duration of no less than six to eight weeks.

All contact information and documentation provided to this office is kept in a secure, encrypted server accessible only to DAI personnel and vetted IT professionals with a technological need for access. Information concerning accommodations or documentation will not be released or discussed without written consent from the student.

All sections of this form must be completed and returned as soon as possible so that we may verify eligibility. Providers may also use their own format as long as the requested information is included, and the letter meets the documentation guidelines posted on our website (see footer). This form and any other relevant documentation may be faxed to 401-874-5694 or emailed to dai@uri.edu.

Thank you in advance for your time and support.

The DAI Team

Student's Name: _____

Date of Request: _____

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Student Information - Completed by the Provider ONLY

First Name _____ Middle_____Last _____

Date of Birth _____

Diagnostic Information

Primary Diagnosis _____ Date of Diagnosis _____

Secondary Diagnosis _____ Date of Diagnosis _____

How was the diagnosis made? (please check all applicable answers)

- ☐ Interviews with the person themselves
- ☐ Interviews with other persons
- ☐ Behavioral Observations
- ☐ Developmental History
- ☐ Educational History
- ☐ Testing **(please enclose a copy)**
  - ☐ Neuro-Psychological Testing
  - ☐ Educational Testing
  - ☐ Psychological Testing
- ☐ Other (please specify) _____

Please indicate the impact on major life activities below

Life Activity	Negligible Impact	Moderate Impact	Substantial Impact	Not Sure
Concentrating	◯	◯	◯	◯
Memory	◯	◯	◯	◯
Social Interactions	◯	◯	◯	◯
Self-Care	◯	◯	◯	◯
Verbal Communication	◯	◯	◯	◯
Written Communication	◯	◯	◯	◯
Reading Fluency and Comprehension	◯	◯	◯	◯
Thinking and Processing	◯	◯	◯	◯
Stress Management/Self Regulation	◯	◯	◯	◯
Sleeping	◯	◯	◯	◯
Managing Internal Distractions	◯	◯	◯	◯
Managing External Distractions	◯	◯	◯	◯
Organization	◯	◯	◯	◯
Other: _____	◯	◯	◯	◯
Other: _____	◯	◯	◯	◯

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Please describe specific functional limitations in the context of a college environment. ***Housing requests require a different form***

In the Classroom Environment	
In the Testing Environment	
Assignment completion (please note that DAI rarely approves accommodations for assignment extensions, as courses are cumulative, organizational resources are available, and keeping pace is a requirement for completion).	
Expressive and Receptive Verbal and Written Communication	
In an applied setting, such as a lab or field placement.	

Medically Necessary Accommodations

Please include medically necessary accommodations recommendations based on the functional limitations noted above.

Certifying Medical Professional

_____ _____

Signature of Medical Professional (required) Date

License # _____

_____

Printed Name and Title Phone # _____