UNT Dallas Office of Disability Accommodation (ODA) Physical Disability Documentation Form

**This box to be completed by student**

Student’s First Name: ______________________ MI: _____ Last: ______________________

UNT Student ID: ______________________ Date form submitted to professional: ______________________

The student named above has requested reasonable accommodations based upon a physical disability at the University of North Texas (UNT). In order to determine eligibility, the UNT Office of Disability Accommodation requires documentation from the appropriate health care professional e.g. Medical Doctor, Nurse Practitioner, Physical or Occupational Therapist, who is not related to the student. This information will be used to determine if the student’s health condition constitutes a disability as defined by the Americans with Disabilities Act of 1990 as Amended and what reasonable accommodation(s) are necessary. Please provide the following information as completely as possible to maximize the student’s prospects of qualifying. The ODA sincerely appreciates your time and effort.

**Remainder of this form is to be completed by a qualified medical professional only.**

Name of health care professional completing form: ______________________ License #: ______________________

Address:_______________________________________________________ Phone:______________________________

Please provide the ICD 9/10 code and standard nomenclature of this student’s medical condition(s):

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Date of Diagnosis: _______________ Most recent date you examined or treated student: ___________

Is the student currently under your care? Yes:______  No:_______ If yes, how long?_________________

**ESSENTIAL:** Will the student’s disability create limitations lasting longer than six months? Yes:_____ No:_____

**Blind/Low Vision Only** (Attach most recent eye exam) Vis Acuity (best corrected) OD:______OS:______ Vision field (degree) OD:______OS:______ Totally blind OD:______OS:______ Light Perception OD:______OS:______ Object Perception OD:______OS:______ Hand Movements OD:______OS:______ Counts Finger: OD:______OS:______

Legally Blind Yes:______ No:______ Primary means of reading text, Enlarged Font______ CCTV, magnifier______ Other (list)___________________________ Eye fatigue issues:_____ Recommended Font Size: ______ NA:______

**Deaf/Hard of Hearing Only** (Attach most recent audiogram) Hearing loss in Db Rt:______Lft:______

Certificate of Deafness Yes:______No:______ Primary communication augmentation Hearing Aid:______

Cochlear Implant:______ FM Loop, audio trainer______ Sign Language:______Other:________________________

The following matrix (page 2) is crucial to establish eligibility. To qualify, the student’s disability must have a severe impact on at least one of the listed life activities, or, moderately impact multiple areas of functioning. Please use your professional judgment to determine the level of impact the student’s diagnosis(es) has on the associated life activity. Attach any relevant medical records especially, eye exams, audiograms, sleep studies, functional capacity exams, VA disability rating etc.
NOTE: When in remission or well controlled conditions such as diabetes, cancer, lupus, epilepsy and other chronic illnesses may present no immediate limitations. Students may still qualify for ADA protection when the potential exists for a previously stable condition to worsen. Please complete the matrix to reflect those periods when the condition is not well controlled. Also, consider side effects of medications and other treatment(s) that may negatively impact life activities. Lastly, completion of this form has no bearing upon a student’s future employability, or eligibility for any services beyond the University of North Texas. To make an eligibility determination we need to know how serious the student’s limitations are. Please do not feel the need to minimize this. Basically, we need to know how severe the student’s health problems can be at their worst.

From the above matrix, please list how you would expect the life activity limitations you rated as severe to impact the student in the educational environment of a large university (e.g. learning, taking tests/notes, class attendance):

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

By signing below I am certifying that I or my designee has completed this form truthfully and accurately.
Signature & Professional Title: ________________________________ Date: ____________________________

Return digital copy to UNTDdisability@untdallas.edu (preferred) or mail/deliver in person to:
UNT Dallas: Disability Services: 7400 University Hills Blvd. Bldg 2, Rm 204; Dallas, Tx 75241  UNTDdisability@untdallas.edu

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