

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.

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

FOR PHYSICAL CONDITIONS ONLY

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.

Life Activity Matrix	No Impact	Moderate Impact	Severe Impact	Don't Know
Speaking				
Hearing (attach most recent audiogram)				
Seeing (attach most recent eye exam)				
Lifting				
Standing				
Walking				
Sitting				
Manual dexterity/Writing				
Sleeping				
Concentration				
Memory				
Reading				
Caring for Self				
Class Attendance				
Bodily functions (immune system, digestive, circulatory, endocrine etc.)				
Communication (receptive & expressive)				
Sustained Focus				
Other (Please list)				

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: _____