UNIVERSITY OF NORTH TEXAS
OFFICE OF DISABILITY ACCOMMODATION

FOR PHYSICAL CONDITIONS ONLY

UNT 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 <u>medical professional only.</u>

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

Address:_____ Phone:_____

Please provide the ICD 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?_____

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:_____

<u>ESSENTIAL For ALL Conditions</u>: *Will the student's disability create limitations lasting longer than six months?*
Yes:_____ No:_____

The following matrix (page 2) is <u>crucial</u> 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.

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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:_____

Return digital copy to odadoc@unt.edu (preferred) or mail, fax, deliver in person to:
UNT ODA • Sage Hall 167 • Union Circ. #310770 •1155 Denton, TX 76203 • F 940.369.7969 • P 940.565.4323 •www.unt.edu/oda