



## Accommodation Provider Documentation Form

### 1. Student Requesting Accommodations

Name: \_\_\_\_\_

Student ID: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

### 2. Authorization of Release of Information (REQUIRED)

By signing below, I authorize Indiana State University Accessibility Resource Office to receive documentation and information, relevant to my request for a housing or academic accommodation, from my provider who I have listed below. I also authorize my provider to discuss my condition(s) and the documentation and information provided with the appropriate Indiana State University personnel on an as-needed basis. This information is kept confidential. Typing name and date into the form constitutes an electronic signature.

Provider Name: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider City: \_\_\_\_\_

Provider State: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian signature is only required if student is under 18 when the document is submitted

### 3. Information for Provider

The above-named student has requested academic and/or housing accommodations for a disability at Indiana State University. The Accessibility and Advocacy Resource Office is attempting to determine whether this student has a condition or combination of conditions that affects one or more aspects of the student's daily life beyond what a reasonable person without a disability would expect to experience during their lifetime. Current and comprehensive documentation will assist the Accessibility and Advocacy Resource Office in determining whether an accommodation is necessary to provide equal access to education.

**Documentation and all relevant information must be completed or provided by an appropriately qualified licensed clinical professional or healthcare provider who has seen the student in-person in the past twelve months and is familiar with the history and functional limitations of the student's condition(s). Documentation completed by a family member is not acceptable. All documentation will be evaluated on a case-by-case basis.**

Please attach any additional sheets, other information, evaluations, etc. which are relevant to the student's current condition and supports the student's request for an academic or housing accommodation at Indiana State University.

### 4. Provider should completely respond to the following:

A. How long has the student been under your care, and when was the last time you saw the student?

B. What is the specific diagnosis(es) or condition(s) that impact the student's equal access to education? How long has the student experienced this condition(s) and what is the expected duration?

#### **4. Provider should completely respond to the following: (continued)**

C. What is the evidence supporting the diagnosis(es)? (Ex. DSM-V, Weschler Adult Intelligence Scale, etc.).

D. Which major life activity/activities is/are impacted by the student's condition(s)? To what degree are they impacted (mild/moderate/severe)? Please explain.

E. What accommodations(s) are you recommending to address the items mentioned in Section D (above) ? **How will this provide equal access to education/housing?**

F. Is there any additional information you would like to add that might be helpful to us in working with this student?

#### **5. Provider Signature**

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

License or Certification: \_\_\_\_\_ State: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Date Received:**

**Received by:**

Contact The Accessibility and Advocacy Resource Office with questions  
at ISU-AARO@indstate.edu or call the office coordinator at 812-237-3822

AARO Fax Number: **812-237-4693**