SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

Accessible Campus Community &
Equitable Student Support (ACCESS)

t 618.650.3726 F 618.650.5691 e myaccess@siue.edu w siue.edu/access
a Student Success Center, Room 1203, Campus Box 1611, Edwardsville, Illinois 62026-1611

ACCESS Documentation Guidelines Companion Form

Section 1: Student Information and Authorization

Student's Name: _____

Student 800#: _____ **Date**: _____

I authorize Accessible Campus Community & Equitable Student Support (ACCESS) at SIUE to release and/or receive information from/to the provider below. I also authorize my provider to discuss my condition(s) with the ACCESS office for the purposes of approving a housing accommodation:

Student Signature: _____

Section 2: For Completion by **PHYSICIAN**

Your patient has self-identified to the ACCESS office as having a physical disability or a chronic health condition covered by the Americans with Disabilities Act as Amended (ADAAA). The following questions are based upon the documentation requirements guidelines issued by the Educational Testing Services (www.ets.org) and Association for Higher Education and Disability (www.ahead.org).

Provider Information

Name of Provider: _____

License #: _____ State: _____

Address: _____

_____

Phone #: _____ Fax #: _____

Medical Facts

Please provide a specific diagnosis (or diagnoses) of the student's condition. Note that a diagnosis in and of itself does not automatically warrant approval of requested accommodations.

Disability/Diagnosis:

Major Life Activity Limitation(s): Based on the student's condition, please describe any functional limitations they may have in performing a major life activity. A current functional limitation is a substantial impairment in an individual's ability to function with respect to the condition, manner, or duration of a required major life activity. Examples include walking, sitting, standing, seeing, hearing, speaking, breathing, learning, working, caring for oneself and performing manual tasks.

Medication(s): If the student is taking medication for this condition(s), how might the medication impact the student? Please include information about what medications are being taken by the student and what adverse impacts if any they may have on their educational pursuits:

Recommendations and Rationale: We would like to have rationale for each recommended accommodation to be provided based upon a medical reason. If there are specific accommodations you feel would be necessary for this student's academic support, or accommodations that the student is requesting which you can affirm, please list those below. If there is any other information you feel would be helpful in assisting this student, please also provide this information.

Section 3: Intermittent Absences Only (if this does not apply, please skip to the signature)

Please fill out this section if the student needs to be out of school/class intermittently (interrupted, non-continuous) due to the patient's own serious health condition.

1. **Will the patient need to be out of school/class and/or unable to participate in regular daily activities on an intermittent basis for illness or incapacity?** Yes ☐ No ☐

   If yes, please provide the following for any and all that apply:

   a. **Will absences be planned and scheduled (i.e. predictable recovery periods after chemotherapy, etc.)?** Yes ☐ No ☐
   b. **Will absences be unplanned and unscheduled (e.g, episodic incapacity)?** Yes ☐ No ☐
2. **Will the patient be out of school/class on an intermittent basis to attend appointments (for treatments, therapy, etc.) due to the serious health condition listed in Section 2?** Yes ☐ No ☐
   a. **How long has the student had this condition?**
   b. **What is the severity of the condition? (Please Check One)** Mild ☐ Moderate ☐ Severe ☐
   c. **What is the expected duration of this condition?**

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3. **Please state the following:**
    a. Date of first contact with student
    b. Date of last contact with student
    c. Frequency of appointments with student

4. **Based on the patient's medical history, please estimate the frequency of episodic incapacity**
    a. Times per week:
    b. Weeks per month:

5. **Will the serious health condition causing episodic incapacity prevent the patient from contacting their instructor(s) to make arrangements for missed assignments or exams?**
    Yes ☐ No ☐

6. **If yes, what is a reasonable amount of time after an episode that the patient should be able to resume regular communication and assigned coursework?**

Medical Provider's Signature **Date**

Upon completion, please return to ACCESS office at Southern Illinois University Edwardsville by email or fax.