

Documentation of Disability

Please Scan and Email Documentation To:

Amy Holt, ADA Coordinator

Amy.Holt@Frontier.edu

859-251-4667

Student Information:

Name: _____

Date of Birth: _____ Phone: _____

Address: _____

Certifying Health Professional:

Name: _____

Professional Title: _____ Highest Degree: _____

Phone: _____ Email: _____

Address: _____

Licensing credential, number, and state: _____

Report Date: _____

Diagnosis (es): _____

Date that pertinent diagnosis was made: _____

Date of provider's recent encounter with this student: _____

Brief History:

Please include onset of symptoms, progression to date, any trauma involved, method of evaluation and results. Additional relevant medical documentation or clinical comments may be submitted on letterhead.

What (if any) major life activities are impacted by this diagnosed condition (e.g. work, learning, etc.)? Please describe the impact below:

Suggested accommodation(s) in professional school as suitable for a distance education program:

Please list any medications prescribed for this student:

Does this student take medication or undergo treatment that may adversely affect performance or behavior? YES | NO

If "yes," please describe below:

How often do you need to see this student to monitor and/or evaluate this diagnosed condition?

In your opinion, does this student represent a potential danger to self or others, *including patients under his or her care in a medical setting*? YES | NO | NOT SURE

If "yes" or "not sure," please explain on letterhead.

Signature: _____ **Date:** _____

Please Return To: Amy Holt, ADA Coordinator | Amy.Holt@Frontier.edu | 859-251-4667

If hard copy items must be mailed, please mail to:

Frontier Nursing University

Attn: Amy Holt

2050 Lexington Road

Versailles, KY 40383