Revised September 2024

Documentation of Disability

Please submit documentation to accessibility@frontier.edu.

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 submit documentation to accessibility@frontier.edu.

If hard copy items must be mailed, please mail to:
Frontier Nursing University
Attn: Disability Services Coordinator, Amy Holt
2050 Lexington Road
Versailles, KY 40383