



Disability Support Services (DSS) Medical or Mental Health Provider Form

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide **current** (within 3 years) documentation of their disability. This documentation should provide information regarding the onset and severity in order to establish that an individual is covered under ADA and Section 504 of the Rehabilitation Act of 1973. Documentation must demonstrate that the individual has a disability and that it substantially limits some major life activity, including learning.

The UW-Superior student is responsible for giving this form to the medical or mental health provider and assisting its return to Disability Support Services.

The student should complete this page (page 1), the provider should complete pages 2 & 3. The provider should return all materials to:

**University of Wisconsin-Superior
Disability Support Services
Belknap & Catlin, PO Box 2000
Swenson Hall 1025
Superior, Wisconsin 54880
disability@uwsuper.edu
Phone: (715) 394-8110
Fax: (715) 394-8441**

STUDENT RELEASE OF INFORMATION

I, _____ (UW-Superior student print name), hereby authorize the release of requested information to **Disability Support Services at the University of Wisconsin-Superior** for the purpose of determining my eligibility for educational accommodation.

Student Signature

Date

Should you need additional space outside of what is provided, please send a letter alongside this form.

1. Medical or Mental Health Diagnosis:

2. Date of most recent evaluation:

3. Please describe the severity of the disability, including functional limitations the student may experience or does experience.

4. Please list the assessments, instruments, and evaluation measures you used to make this diagnosis. ***You can include results as a separate document to this form.***

5. What disability related needs, including recommendations for academic accommodations, adjustments and/or auxiliary aids, are needed for this student, based on your professional evaluation and treatment? ***Please be detailed.*** The information provided in this will be used in determining what accommodations are appropriate and reasonable.

6. Is this student on medication(s) related to this? If so, please list meds and describe any medication side-effects that may be anticipated.

7. Describe the prognosis and anticipated duration of the disability and/or limitations the student experiences.

Please attach/include any additional assessment information that might be helpful in providing appropriate accommodations, i.e. evaluations done by a speech pathologist, neuropsychologist, occupations therapist, psychologist, psychometrist, physical therapist, etc.

Thank you for your help in providing this information so that we may begin providing services as soon as possible. Please return this form to the address shown on page one.

Your signature, address, and licensure information is required (please print).

Your Name _____

License #:

Title:

Place of Employment:

Phone:

Signature _____