**Healthcare Provider Form**

**Instructions:** The purpose of this form is to gather information to assist the Mount Carmel College of Nursing Accommodations Coordinator to determine the extent of a student’s disability and what accommodations may be appropriate. The information contained on this form is protected by FERPA.

**Note:** This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions. Once completed, this form should be submitted to Student Accessibility Services either by the student or directly from the healthcare provider using the contact information below:

Student Accessibility Services

Attn: Accommodations Coordinator Phone: 614-234-2341

Mount Carmel College of Nursing Fax: 614-234-5979

127 S. Davis Ave. Email: [accessibility@mccn.edu](mailto:accessibility@mccn.edu)   
Columbus, OH 43222

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| **STUDENT INFORMATION**  **(MCCN Student to Complete this Section)** | | |
| Name (Last, First, Middle Initial) | | Phone (with area code)  □ Cell □ Home □ Work |
| Student ID Number | Date of Birth | Campus & Program □ Main □ Fairfield □ Online  □ BSN □ SDAP □ RN-BSN □ MS □ DNP |

**Release:** I hereby authorize the healthcare provider listed below to release the information requested below to the Mount Carmel College of Nursing Accommodations Coordinator for the purposes of evaluating my request for academic accommodations.  
Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **QUALIFIED HEALTHCARE PROVIDER INFORMATION (Healthcare Provider to Complete this Section)** | | |
| Name:   Credentials/Licensing: □ MD/DO □ PhD (Psychology)   □ APRN □ LISW/LPCC/LMFT  □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Area of Certification/Board Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Phone (with area code)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (with area code)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: | | Email: |
| **DISABILITY ASSESSMENT (Completed by the Qualified Healthcare Provider)** | | |
| 1. What is the specific diagnosis/health condition? Please provide the relevant DSM-V or ICD-9/ICD-10 code: | | |
| 2. When was the diagnosis made? | 3. When did you last see the student? | |
| 4. Does the student need to be re-evaluated on a regular basis for the condition? If yes, how often? | | |
| 5. How did you make the diagnosis? (Please describe the tests, methods, or diagnostic procedures used to make the diagnosis.) | | |
| 6. Describe the current symptoms of the diagnosis (es) that the student experiences. Describe the extent to which the student’s condition(s) limit one or more major life activities. (Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.) | | |
| 7. What is the current treatment plan? If applicable, list current medications and any side effects. | | |

*By signing below, I certify that the information submitted here is accurate and that I am a qualified healthcare provider properly licensed and credentialed to diagnose and treat the stated conditions.*Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_