



5501 S. Ellis Avenue, Chicago, IL 60637 773.702.6000 disabilities.uchicago.edu

PROVIDER REPORT FOR ACCOMMODATIONS REQUEST -
This form may not be completed by a relative of the patient

Student Name
(Please Print): _____

DOB: _____

As the student's treating medical provider, please answer the following questions:

1. Please describe the student's impairment giving a specific diagnosis. Include date of diagnosis and date of last clinical contact with student.
2. Is the impairment you described permanent or temporary?
3. Provide a description of the functional impact of the diagnosis or medical condition. Describe the current functional impact on physical, perceptual or cognitive abilities.
4. How does the impairment specifically impact the student's ability to perform in an educational setting?



9. Please provide any additional information or diagnosis that you feel will be useful in determining the nature and severity of this student's medical condition in helping to determine disability eligibility, and any additional recommendations that may assist The University of Chicago in determining appropriate accommodations and interventions:

**I certify, by my signature below, that the information provided above is true and accurate.
Please print clearly.**

Signature: _____

Date: _____

Print Name and Title: _____

Area of Specialty: _____

State of License: _____ License Number: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

Return this information to:
Student Disability Services
University of Chicago
5501 South Ellis Avenue
Chicago, Illinois 60637
Fax: 773-926-0996/disabilities@uchicago.edu