Accommodations Qualified Professional Form

This form is to be completed in full by the Physician/Therapist.

Student Name:	
Clinician Name:	
Medical Specialty:	
License/Credential:	
Address:	
Phone:	
Date Completed:	

To Whom It May Concern:

A patient/client of yours is enrolled at Rasmussen University and has requested disability-related accommodations in order to participate in their educational program. Legal protection and eligibility for such accommodations are based on the provision of sufficient information to conclude that the person:

- ***Has an impairment/disability.***
- ***That this impairment/disability substantially limits one or more major life activities AND***
- ***That as a result of the substantial limitations of this impairment/disability, accommodations are required in order for this person to participate in their educational program.***

As this student's treating specialist, you are asked to provide the following information to allow the University to consider this student's accommodation request.

<u>The Condition of Patient/Client</u>

1. What is the diagnosed impairment/disability?

2. Date of original diagnosis?

3. Is the patient/student currently under your care?

4. Is the impairment/disability temporary (<6 months) or persistent? If temporary, what is the timeframe for recovery?

5. How do you see the student's impairment/disability impacting their ability to perform educational activities in relation to how most other people are able to perform these activities?

6. What accommodation(s) would they need to perform the same activities or tasks?

FUNCTIONAL IMPACT ASSESSMENT

Please check and complete the following:

THE LIMITATION IS: 1=Unable to Determine 2=Mild 3=Substantial

1	2	3	Major Life Activity		1	2	3	Major Life Activity
			Caring for Oneself					Learning
			Talking					-Reading
			Hearing					-Writing
			Breathing					-Spelling
			Seeing					-Calculations
			Walking/Standing					-Concentrating
			Lifting/Carrying					-Memorizing
			Sitting					-Listening
			Performing Manual Tasks					Other:
			Eating					
			Working					
			Interacting with Others					
			Sleeping					

For any area that was marked as substantial, please provide a description of how the impairment/disability affects this area of functioning. ***This area must be completed to process the student's accommodation request. Please take the time to fill this out.***

Area that is substantially impacted.	Description of how the impairment/disability affects this area of functioning.
Example *Concentration*	*Easily distracted by noises in the classroom and can be drawn off-task by something as simple as the movement of a chair or turning of a paper by another student.*

Please indicate accommodations you feel would be helpful in the academic environment for this student in order to reduce/remove barriers created by their impairment/disability.

Check if recommended	**Instructional Accommodations**	**Explanation**
	Extended time	
	Copies of notes/PowerPoints	
	Record lectures	
	Other _____	
	Testing Accommodations	
	Calculator	
	Distraction reduced	
	Extended time	
	Text-to-speech reader	
	Headphones	
	Other _____	
	Support Services	
	Interpreter	
	Lab assistant	
	Other_____	
	Environment	
	Adjustable table	
	Preferential seating	
	Space for wheelchair	
	Taking breaks	
	Beverage/snack in class	
	Other_____	
	Equipment	
	Adaptive computer software	
	Closed captioning	
	FM system	
	TTY/TDD	
	Physical textbooks	
	Amplified stethoscope	
	Fidget device	
	Other_____	

Signature: **Date:**

Official Office/Clinic Stamp Here: