Trinity College
HARTFORD
CONNECTICUT

Accessibility Request - Provider Form

Dear Student: Please ask your provider to complete this form as documentation for your ADA request. Initial box below if you ***do not*** give permission to contact your provider if necessary.

☐

Dear Provider: You are being asked to provide documentation of at least one disability for your patient/client. Please fill out the form below and attach the appropriate supplemental documentation. Thank you in advance for your support and cooperation in this matter.

Practitioner/Title_____Date_____
Address_____
Phone Number_____ License or Certification Number_____
Specialty/qualification to make diagnosis_____
Student Name_____ Date of last visit_____

Important: To be eligible for services, the student must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act (ADA). These laws define a person with a disability as one who 1). has a physical or mental impairment that substantially limits one or more major life activity, or 2). has a record of such impairment, or 3). is regarded as having such an impairment.

What is the diagnosis that impacts the student's physical and/or cognitive function? **Please include expected duration:**

What is the evidence supporting the diagnosis? Please provide a copy of any test results supporting the diagnosis (i.e. psycho-educational evaluation, audiogram, etc.) or other information used to determine the diagnosis.

How long has the student experienced the condition and what is the expected duration?

Is there a follow up plan?

What specific physical and/or cognitive functioning is impacted or limited by the condition (s)? What is the level of that impact? Please explain. Please read the criteria above that outlines a disability as defined by federal laws.

FUNCTIONAL LIMITATIONS	Mild	Moderate	Substantial	Duration/ Comments
Caring for oneself				
Performing Manual Tasks				
Seeing				
Hearing				
Breathing				
Sleeping				
Eating				
Standing				
Lifting				
Bending				
Walking				

FUNCTIONAL LIMITATIONS	Mild	Moderate	Substantial	Comments
Speaking				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Working				
Operation of a major bodily function				
Other				

Which accommodations are appropriate for your client. Each recommendation must be supported by the diagnosis. Please provide rationale for each suggested accommodation relating it to a specific functional limitation. Please state alternatives to meet the documented need if the first request cannot be met.

Is there any other information you would like to add that might be helpful in working with this student?

Signature of Specialist Date

Please summit to student and/or Email:
SARC@trincoll.edu