SAN JUAN COLLEGE

San Juan College Health Care Provider Form

Purpose of this Form

At San Juan College Accessibility Services (AS) approves academic accommodations for students. Information provided on this form is only used to assist AS in determining if this student's physical or mental health condition meets eligibility requirements and what accommodations may be appropriate.

The information provided to AS on this form is protected by Family Educational Rights and Privacy Act (FERPA). To learn more about FERPA please visit SJC FERPA page. If needed, the student can request a Release of Information Authorization Form from the Accessibility Services Coordinator.

Please legibly and thoroughly discuss the educational effects of the stated disabilities in this form. This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated condition(s).

This form should not be used to document learning disabilities or traumatic brain injuries

How to Submit

Once this form has been completed it should be submitted to AS. The student can upload this form to their application or it can be scanned and emailed ASO directly by the student or healthcare provider via the contact information below:

Accessibility Services Office
San Juan College
4601 College Blvd
Farmington, NM 87402

Phone: 505-566-3271
Fax: 505-566-4408
Email: accessibilityservices@sanjuancollege.edu

Student's Name: _____ DOB _____

Phone: _____

By signing below, I consent to allowing my healthcare provider to share any information relevant to my need for accommodations, as shown on this form, with Disability Services for the next 60 days (about 2 months).

Student Signature:_____ Date _____

STUDENT INFORMATION

(SJC Student Completes This Section)

Name: _____ Phone: _____

Student ID Number: _____Date of Birth_____

HEALTHCARE PROVIDER INFORMATION

(Healthcare Professional Completes This Section)

Name: _____ Credentials and Licensing Information: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

DISABILITY ASSESSMENT

(To be completed by a qualified healthcare provider)

1. What is the specific diagnosis/health condition? Please also provide the relevant DSM-V or ICD code.

_____

_____

2. When was the diagnosis(es) made?

_____

_____

3. Before today when did you last see the student?

_____

4. How did you make the diagnosis(es)? What tools or methods (e.g., Connors ADHD Rating Scale) were used to evaluate the students' symptoms?

5. Do the symptoms of the diagnosis(es) or treatment plans need to be reevaluated on a regular basis? If yes, how often?

6. Please describe the current symptoms of the stated diagnosis (es) this student experiences. Example: Students dominant wrist is immobilized.

7. Check all of the major life activities that the diagnosis(es) and/or treatment plan affect. What is the level of difficulty? (i.e., Mild, Moderate, Significant or Unable to Perform)

☐Caring for oneself: _____	☐Bending: _____
☐Performing manual tasks: _____	☐Speaking: _____
☐Seeing: _____	☐Breathing: _____
☐Hearing: _____	☐Learning: _____
☐Eating: _____	☐Reading: _____
☐Sleeping: _____	☐Concentrating: _____
☐Walking: _____	☐Thinking: _____
☐Standing: _____	☐Communicating: _____
☐Sitting: _____	☐Working: _____
☐Reaching: _____	☐Interacting with Others: _____
☐Lifting: _____	☐Operation of a major bodily function: _____

8. What is the current treatment plan?

9. Is this a permanent disability or temporary? If temporary, how long is the expected duration?

10. How does the diagnosis(es) significantly affect the student's performance in academic settings?

11. How does the medication and/or treatment plan significantly affect the student's performance in academic settings?

12. If the student experiences episodic flare-ups of their condition, please describe any triggers of episodes, the frequency and duration of episodes, and care plan for management/recovery of the episode.

13. Additional Recommendations.

By signing below, I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature: _____ Date: _____