STUDENT PHYSICAL/SYSTEMIC DISABILITY DOCUMENTATION FORM

NOTE: THIS IS ONLY TO BE USED TO DOCUMENT PHYSICAL OR SYSTEMIC DISABILITIES. THIS FORM WILL NOT BE ACCEPTED AS DOCUMENTATION OF ADD/ADHD, LEARNING DISABILITIES OR PSYCHIATRIC CONDITIONS.

This box to be completed and signed by the student.

Student Name: ____________________________ Student ID: _______________

Phone Number: _________________ UNTHSC Email: _______________________________

Program: ____________________________ Graduation Year if Applicable: _______________

I understand that I am requesting my practitioner to provide complete and confidential information regarding my diagnosis. I also understand that completion of this form by a qualified practitioner does not guarantee accommodations.

Student Signature: ____________________________ Date: _______________

The above named student has requested accommodations based upon a physical disability at the University of North Texas Health Science Center (UNT Health Science Center). In order to determine eligibility, the UNT Health Science Center ODA Office requires documentation from the appropriate health care professional (e.g. Medical Doctor, Nurse Practitioner, Physical or Occupational Therapist, etc) who is not a family member of the student. This documentation will be used to determine if the student’s health condition rises to the level of disability as defined by the Americans with Disabilities Act of 1990 and the Rehab Act of 1973 and is therefore protected against discrimination. The health condition must represent a SUBSTANTIAL impediment to major life activities.

Please answer the following questions as completely as possible to maximize the student’s chances of qualifying for accommodations. Feel free to write on the back of the form if you need additional space.

Office of Disability Access
Student Service Center (260)
3500 Camp Bowie Blvd, Fort Worth, TX 76107
817-735-2134 Fax: 855-604-0915
www.unthsc.edu/ODA
MAJOR LIFE ACTIVITY ASSESSMENT:

Please Circle the level of limitation created by the student’s diagnosis(es) and if you circle anything other than no limitation, please describe specifically how the limitation can impact the student in the educational setting e.g. taking notes, studying, completing tests on time, reading, navigating the campus, attending class or any other typical components of college life.

SPEAKING

Circle one:  No Limitation  Mild  Moderate  Substantial

Describe academic impact of limitations:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

HEARING

Circle one:  No Limitation  Mild  Moderate  Substantial

Describe academic impact of limitations:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

SEEING

Circle one:  No Limitation  Mild  Moderate  Substantial

Describe academic impact of limitations:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

WALKING

Circle one:  No Limitation  Mild  Moderate  Substantial

Describe academic impact of limitations:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
<table>
<thead>
<tr>
<th>Physical Systemic Documentation Form 2021.docx</th>
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<tbody>
<tr>
<td>BREATHING</td>
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<tr>
<td>Circle one:  No Limitation  Mild  Moderate  Substantial</td>
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<tr>
<td>Describe academic impact of limitations:</td>
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<tr>
<td>STANDING</td>
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<tr>
<td>Circle one:  No Limitation  Mild  Moderate  Substantial</td>
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<td>Describe academic impact of limitations:</td>
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<tr>
<td>LIFTING</td>
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<td>Circle one:  No Limitation  Mild  Moderate  Substantial</td>
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<td>Describe academic impact of limitations:</td>
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<tr>
<td>SITTING</td>
</tr>
<tr>
<td>Circle one:  No Limitation  Mild  Moderate  Substantial</td>
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<tr>
<td>Describe academic impact of limitations:</td>
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<tr>
<td>PERFORMING MANUAL TASKS (DEXTERITY)</td>
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<tr>
<td>Circle one:  No Limitation  Mild  Moderate  Substantial</td>
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<tr>
<td>Describe academic impact of limitations:</td>
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<tr>
<td><strong>WRITING</strong></td>
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<tr>
<td>Describe academic impact of limitations:</td>
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<tr>
<td><strong>SLEEPING</strong></td>
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<td>Describe academic impact of limitations:</td>
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<td><strong>CONCENTRATION</strong></td>
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<td>Describe academic impact of limitations:</td>
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<td><strong>MEMORY</strong></td>
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<td>Describe academic impact of limitations:</td>
</tr>
<tr>
<td><strong>READING</strong></td>
</tr>
<tr>
<td>Describe academic impact of limitations:</td>
</tr>
</tbody>
</table>
CARING FOR SELF

Circle one:  

- No Limitation  
- Mild  
- Moderate  
- Substantial

Describe academic impact of limitations:

OTHER

Circle one:  

- No Limitation  
- Mild  
- Moderate  
- Substantial

Describe additional limitations and academic impact of limitations:

ADDITIONAL INFORMATION

1) Is the student currently under your care?  
   Yes/No (circle one)  
   Length of Care: ____________________

2) What is the current diagnosis(es)? Please use ICD 10 codes:
   _________________________________________________________________
   _________________________________________________________________

3) When did you last examine the student? ________________________________

4) Are the limitations described above permanent, if not how long will they be present?  
   _________________________________________________________________
   _________________________________________________________________

5) List medications which the student is taking and please describe any problematic side effects:
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
6) List any regular treatments the student may be undergoing (chemotherapy, dialysis) and describe how this may create difficulties for the student.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

HEALTH CARE PROFESSIONAL INFORMATION

Full Name of Health Care Professional: ________________________________

License Number: ____________________________

Signature: ____________________________             Date ____________________________

Health Care Professional Address:
Street ________________________________________________________________
City ____________________________ State ________ Zip ____________
Phone: ____________________________             Fax: ____________________________