

Accessibility Services

Provider Documentation Form

PROVIDER INFORMATION		
	Date	
Provider Name (Last, First, Middle Initial)	License Number	
Provider Street Address, City, ST, ZIP Code	Name of Organization	
Primary Phone Number Fax	Email Address	
PATIENT INFORMATION	Date	
Patient Name	Email Address	
Primary Phone Number		
Type of Request		
X Access/copy		
X Confidential communication		
I (student) am requesting accessibility services through the Accessibility Services at Texas Tech University Health Sciences Center El Paso. Accessibility Services requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability-related accommodations. Please respond to the following questions as soon as possible and return to me or send to Accessibility Services by email or fax. I authorize Accessibility Services to contact you if clarification is needed.		
Student Signature	Date	
The following area must be completed by the health care professional listed on this page.		
1. Diagnosis(es) and date(s):		
2. Current status of condition(s) (e.g., active, progressing, controlled, in remission):		
3. Current level of severity (choose one): Mild Moderate Severe		

4. How long is this condition(s) likely to persist (e.g., lifetime, 1 academic year, etc.):	
5. Please list procedures/assessments used to diagnose this student's condition:	
3. Hease list procedures/assessments used to diagnose this student is condition.	
6. What are the functional limitations or symptoms of this condition(s)?	
7. What exacerbates this student's specific disability(ies)? (Please be specific.)	
8. How does this condition impact the student's ability to learn or meet the demands of	f a university setting clinical
requirements, or other educational setting?	r a university setting, clinical
Identify any accommodations you believe may be necessary for the student to parti- programs, activities, exams, and services:	cipate in the university's
programme, activities, evaluation recess	
Please attach any further documentation, if applicable.	
Required attachments:	
For ADD or ADHD: full testing evaluations	
Deaf or hard of hearing: current audiogram	
This information is current and accurate to the best of my knowledge, based on my review of records of a recent evaluation by a qualified health care provider.	ecent evaluation of this patient or my
Provider's Official Signature	Date
Thank you for your cooperation. Please email your report using the information provide additional information. All information on this form will remain confidential in accorda	

Rights and Privacy Act (FERPA).

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