Lebanon Valley College Student Name:_______________ DOB: ___________

FORM B: Medical Provider Information: Chronic Health Impairments (This form is to be completed by a health professional *only if the student has a documented medical/mental health need that requires special accommodations*).

If this form is not filled out entirely, does not answer the question(s), or if it is not filled out LEGIBLY, the form will be returned to the student. If Academic Accommodations are needed, a separate form will need to be completed. Thank you for your assistance.

A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits a major life activity". Examples of major life activities are: walking, speaking, breathing, hearing, seeing, thinking, sitting, sleeping, working, learning, interacting with others, concentrating, performing manual tasks, or caring for oneself.

1. Based on this definition does the individual have a physical or mental impairment? ☐ YES ☐ NO

2. Please answer the following questions:

   a. How long have you been treating the patient / student? _______________

   b. What specifically is the diagnosis(es)? _______________

   c. Which major life activities are affected by the diagnosis(es)? _______________

   d. How many days/months did the diagnosis(es) limit major life activities during the past year? _______________

   e. What is the expected duration of the condition? _______________

   f. What are the expected permanent or long-term effects of the condition? _______________

   g. What medication does the student take, if any, for this condition? _______________

3. What other treatment modalities does the student use? _______________

   ____

4. State specifically what special meal plan/ housing accommodations are recommended and what ***benefits*** these accommodations will have with regard to the individual's condition.

   ____

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   ____

5. Please state specifically what, if any, other recommendations you have for the student.

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Form Completed by: (Please Print)

Provider Name:_______________ Signature _______________

Provider License # _______________ Phone Number _______________

Address_______________

Provider Specialty_______________ Date_______________

Please return completed form to:

STUDENT AFFAIRS OFFICE

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