Yale *Student Accessibility Services*

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Yale Student Accessibility Services
Academic Accommodations Form

Provider documentation form for students with a chronic health condition(s) requesting accommodations.

Student Information:
Name: _____
Phone number: _____
NetID: _____
Yale email: _____

STUDENT (please sign below before providing this form to your provider to complete): By signing below, I consent to allowing my treatment provider to share any information relevant to my request for an accommodation with Yale Student Accessibility Services.

Signature _____ Date _____

HEALTH PROFESSIONAL
The remainder of this form is to be filled out by a health professional who is CURRENTLY TREATING THE STUDENT.

The above-named student has indicated that you are their current treatment provider. Generally, Student Accessibility Services (SAS) accepts documentation from providers that have a clinical relationship with the student. The named student has signed this form giving written permission for you to share information regarding their condition and the impact on them with SAS. If SAS needs additional information, we may contact you. Thank you.

So that SAS may evaluate the student's request for accommodation(s), please answer the following questions. Alternatively, a provider may send a letter that includes the information requested below.

Diagnosis Information:

1. **Diagnosis:** _____
2. **Date of Diagnosis (Dx):** _____
3. **Severity of Condition (please check one):**

☐ Mild
☐ Moderate
☐ Severe

☐ In Remission

4. **Is the condition stable or is it likely to change over time? If changes are expected, please describe:**

   ___ Stable ____ Episodic ___ Slow progression ___Rapid progression ___Improving

   Expected Changes: _____

5. **Please describe the symptoms of the condition(s) when in an active state, including frequency and duration, if applicable:**

Symptom(s):	Frequency	Duration

6. **Treatment and/or medications currently being used:**
   - Treatment: _____
   - Medications: _____
   - Side effects: _____
7. **Anticipated prognosis and medical follow-up:**
   - Prognosis: _____
   - Recommended Follow-up:

     _____
8. **Functional limitation(s) / impact caused by condition(s), or its treatment, on daily living for this student:**

- Physical Activities Impact:

  _____
- Social/Emotional Impact: _____
- Other: _____

9. **Are there any exacerbating factors that cause flare or worsening of the condition? If so, please list them:**
   - Factor: _____
10. **How does the condition specifically affect the student's ability to perform academic tasks (e.g., concentration, class attendance, ability to meet deadlines)?**

    Academic Impact Details: _____

11. **Is there any other information you believe is relevant to understanding the student's condition and needs?**

    _____

Provider Information:

Provider Name (please print):
_____
Provider Signature: _____ Date:_____
Provider License Number and area of specialization:
_____
_____
Provider
Email: _____
Provider
Phone: _____
Provider Address: _____
☐ Yale Health or Yale Mental Health and Counseling
☐ If an outside Yale provider, please include address:
_____