Robert Morris University

Student Accessibility Services (SAS)
Phone: 412-397-6884 SAS@RMU.edu

STANDARD DOCUMENTATION FORM

RMU Student Portion:

Student Name: ____________________________________ RMU ID #: _______________

Student Email: ____________________________________ Phone Number: _____________

For Housing & Dining-related accommodation requests, please see page 3. *I am requesting accommodation(s) through Student Accessibility Services (SAS) at Robert Morris University. In order to receive accommodations at Robert Morris University, students must send current and comprehensive documentation of student disability/medical condition. All documentation is kept confidential. For information on appropriate documentation, see the Services for Students with Disabilities website:* RMU.edu/SAS

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Medical/Mental Health Professional Portion:

This form is required to be mailed or emailed to the RMU SAS Office directly by the Physician's Office.

Physician/Provider name (print): ______________________________ Title: __________________________

Phone: __________________________ Fax: __________________________

Organization & Address: ____

Describe your professional credentials: ____

____

This form must be completed by the Medical/Mental Health Professional listed above.

Diagnosis(es)/DSM-V/ICD-10 Codes: ____

Diagnosis date: _______________________________

Level of Severity: ☐ Mild ☐ Moderate ☐ Severe

Duration: ☐ Permanent ☐ Chronic/Recurring (likely to last the duration of college attendance)

☐ Temporary **Date disability will end**: ___________ (Accommodations not necessary after this date)

Is the above-mentioned student currently under your care for the condition?

☐ Yes ☐ No

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What assessments/instruments were used to determine diagnosis? _____

_____

What treatment and/or medications are currently in place? _____

_____

Please describe the specific functional limitations resulting from the impact of the disability, symptoms, or medication side effects:

_____

_____

_____

What accommodations are appropriate to compensate for the limiting functions mentioned above?

_____

_____

_____

_____

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient and/or my review of records.

Please print this form out and manually sign this form. Do not type signature.

Physician/Therapist Signature: _____ Date: _____

License # _____

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HOUSING AND DINING ACCOMMODATIONS

Does this student require Housing Accommodations in order to treat diagnosis listed on page 1?

☐ Yes ☐ No

What treatment has been provided to address the diagnosis and symptoms? Is treatment ongoing? If not, please list start and end dates of treatment.

_____

_____

Please describe and explain the functional limitations resulting from the impact of the diagnosis on major life activities: _____

_____

_____

Please state specific recommendations for this student's housing accommodations and explain why these accommodations are medically necessary given their diagnosed condition and associated disability. ***(Note: If requesting a single room, please indicate whether the student can share communal living space and/or bathroom with others in the dormitory generally or with roommates/suitemates. If student cannot share communal living space and/or bathroom, please explain why not.)***

_____

_____

_____

_____

_____

_____

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HOUSING AND DINING ACCOMMODATIONS

Student is allergic to: (Please check all that apply)

☐ Dairy ☐ Fish ☐ Soy ☐ Tree Nuts
☐ Eggs ☐ Peanuts ☐ Shellfish ☐ Wheat/Gluten
☐ Other (please specify): _____

Please describe clinical severity of allergy: _____

_____

If student has another medical condition that requires Dining Accommodations, please specify details here: _____

_____

_____

How did you (the provider) derive these specific recommendations? Please check all that apply:

☐ Student or parent's request for specific accommodations
☐ Clinical assessment to determine the need for accommodations
☐ Mutual agreement determined through discussion between clinician and student/client
☐ Other (please explain): _____

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Please print this form out and manually sign this form. Do not type signature.

Physician/Therapist Signature: _____ Date: _____

License # _____