Provider Recommendation Form

Alma College Student Success Office

Disability Services

614 W. Superior, Greg Hatcher Learning Commons

Alma, MI 48801-1599

Phone: 989-463-7428 **Fax**: 989-463-7126

disability_services@alma.edu

The information submitted to Disability Services should reflect the most currently available information. This form must:

1. Be completed by a qualified medical or mental health professional. Diagnoses of disabilities documented by family members are unacceptable.
2. Be completed by a professional with first-hand knowledge of the condition(s) and sent directly from the provider's office. Form will not be accepted from students.
3. Be completed as clearly and thoroughly as possible. We recommend typing answers into the fillable PDF, as illegible handwriting will require additional follow-up. To access the fillable PDF, click "Fill & Sign" in the Toolbar on the right side of Adobe.
4. Be completed with the understanding that the Americans with Disabilities Act (ADA) defines the term “disability” as a physical or mental impairment that substantially limits one or more major life activities. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Note: Section I must be completed by the student’s provider for all accommodation requests. If the student is requesting an Assistance Animal, further information is required at the end of Section II by a provider who has observed the student interacting with their animal.

Fax completed form to: **989-463-7126** or securely email to: **disability_services@alma.edu**

ALMA COLLEGE

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Section 1: All Fields are Required for Consideration

Date: ___________________

Provider Name: ____

Provider Employer/Office: ____

Office Address: ____

Office Address – Line 2: ____

City: ______________________________ State: __________ Zip: _________

Office Phone Number: ____

Patient/Student Name: ____

By typing your name here, you are confirming this patient/student has a diagnosis that warrants reasonable accommodations under the Americans with Disabilities Act, as recently amended, and/or Section 504 of the 1973 Rehabilitation Act, qualifying them for disability services.

____

Signature/ E-signature here

Section 2:

Describe the impacts it has on the student's daily life and/or learning outcomes:

(What major life functions are impaired? What are the barriers to equal access?)

Accommodation categories:

___: Housing

___: Meal Plan

___: Emotional Support Animal

___: Academic

___: Other: ____

Please describe in detail the accommodation being prescribed:

Expected benefits and improved outcomes of the accommodations:

List any previous historical support regarding the requested accommodations for the student (past visits, past treatment, modifications and adjustments):

(**Complete this block only if it pertains to emotional support animals or ESA)**
By typing your name here, you have observed the student and the support animal together in various sessions, and are prescribing this as a recommendation for treatment for the qualifying disability:

____

Please describe the observations of the student and the support animal here:

Please include your signature as confirmation that everything in this document is truthful and accurate to the best of your knowledge and historical context with this student:

____

Section 3:

Please email or fax this completed PDF form to disability_services@alma.edu or at 989-463-7126. Include the student's name in the subject line, and attach any other letters (on letterhead), and/or supporting documents.