Central Methodist University
Center For Learning & Teaching –Disability Services
Medical Release Form

SECTION A: STUDENT INFORMATION (Completed by the student)

INSTRUCTIONS: Complete student information and health care provider information, and sign authorization release below. Send form to your health care provider. Make additional copies of this form for each of your health care providers, if you have more than one provider.

Student Name: _____ Student ID#_____

Date of Birth: _____ Email: _____

Home Address: _____ Local Address: _____

_____ _____

Home Phone Number: _____ Cell Phone Number _____

☐ I hereby authorize Central Methodist University to receive information from the provider below. I also authorize my provider to discuss my condition(s) with the appropriate Central Methodist University (CMU) personnel on an as-needed basis.

☐ I hereby authorize the Disability Service Staff for CMU to communicate directly with the health care provider who completes this form to obtain clarification of issues relating to the functional limitations for which I am seeking an accommodation.

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Student Signature: _____ Date: _____

SECTION B: HEALTHCARE PROVIDER (Completed by Healthcare provider)

DOCUMENTATION GUIDELINES:

Acceptable documentation must reflect the following:

- Current documentation (in most cases, within 18 months)
- A specific diagnosis
- Specific findings in support of all diagnoses
- A description of the student's functional limitations as they are directly related to the stated disability
- Specific recommendations for accommodations for curriculum, instruction, testing and/or physical accessibility

INSTRUCTIONS:

To properly evaluate how Central Methodist University can best meet the student's need for reasonable accommodations, the University requires specific diagnostic information from a licensed clinical professional or health care provider. The professional provider should be a regular provider to the student and be familiar with the student's history and functional limitations of the student's physical or psychological condition(s). The provider completing this form **cannot** be a relative of the student. **The provider should completely respond to all questions.** Additional related information may be attached.

Student's Full Name: _____ Birthdate: _____/_____/_____

To determine the eligibility for ADA Accommodations under The Americans with Disabilities Act (ADA) of 1990, Central Methodist University of Fayette, Missouri requests current and comprehensive documents of the student's condition from a licensed clinical professional or healthcare provider that is familiar with the history and functional limitations of the student's condition(s).

1. Student's disability/diagnosis:
   _____
   _____
   _____
   _____
2. When was the condition(s) first diagnosed? _____
3. How would you describe the severity of this condition(s)? _____
4. How long is this condition(s) likely to persist? _____
5. When was the student/patient last seen by you? _____
6. What treatment or medication has been prescribed? _____
   _____
   _____
7. Does the student's disability/health condition significantly limit any major life activities? If yes, please describe the limitations and/or restrictions in detail. _____
   _____
   _____
   _____
   _____
8. Is this disability/health condition temporary? ___ If yes, give ending date _____

9. Please state specific recommendations regarding the accommodation(s) this student needs and explain why such an accommodation is warranted based upon the student's physical or psychological condition(s). _____

_____

_____

_____

_____

_____

_____

All fields below must be completed to process documentation.

Signature of Provider: _____ Date:_____

License # _____ State: _____

Print Name and Title: _____

Address:

_____

_____

Phone: _____ Email: _____

COMPLETED FORM SHOULD BE FAX OR EMAILED <u>BY HEALTHCARE PROVIDER</u> TO:

Maryann Rustemeyer
Director of the Center for Learning & Teaching
FAX NUMBER: 660-248-6898
EMAIL: mrusteme@centralmethodist.edu

CONFIDENTIALITY NOTICE: Medical-related information shall be kept confidential and maintained separate from other personnel records. However, supervisors and managers may be advised of information necessary to the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.

For CMU Internal Use Only:
Date Received: _____ Initials: _____ Additional Documentation Required: _____
Date Reviewed: _____ Accommodation Approved: _____ Denied: _____ Initials: _____