



Dear Mental Health Care Provider:

One of your clients has requested a medical accommodation at St. John Fisher College. The Health & Wellness Center will review the information you provide and make a recommendation to the designated College representatives for appropriate medical accommodations based on the diagnosed disability. The documentation provided regarding the diagnosed disability must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. **The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.** In addition, in order for a student to be considered eligible to receive an accommodation, the documentation must show functional limitations that impact the individual in a residential setting.

Current and comprehensive documentation is required in order to determine appropriate services and accommodations. The information below outlines what is needed to evaluate eligibility for medical accommodations.

Supporting information form is to be completed by mental health care providers. Disability forms cannot be completed by a relative or friend of the student or his/her family requesting the accommodation.

- **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. **The mental health care provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.).**
- **After completing and signing this form, including the Mental Health Care Provider Information Section on the last page, please fax to 585-385-8299 or mail to the Health & Wellness Center at the address below.** The information you provide will *not* become part of the student's educational records, but it will be kept in the student's medical file, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information that would be relevant to assist us in making a determination for a medical accommodation.
- When the documentation is received by the Health & Wellness Center, the student will receive email notification.
- Once completed documentation is received, the Disability Review Committee will review the request. After a decision is determined, a letter or email will be sent to the student outlining what non-academic accommodation(s) (if any) will be made.
Documentation for the request must be received by the Health & Wellness Center by the established deadline:
 - Requests for housing accommodations and supporting documentation for **new students** must be received by the housing application deadline.
 - Requests for housing accommodations and supporting documentation for **returning students** must be received by January 30th for the following fall semester.

Note on Single Rooms and Private Bathrooms:

While a request for a single room will be reviewed; however, **the provision of a single-room as an accommodation is not common.** A single room does not guarantee privacy or a quiet environment. Students who need to study in a quiet environment can utilize quiet spaces on campus such as rooms in the library. A single room also does not guarantee an allergen-free environment. A single room will not prevent a student from having to interact and negotiate living arrangements with other students, such as alone time, sleep patterns, and study schedules. In community bathrooms, there are several toilets within the bathroom that are for shared use of the residents on the floor, as well as a private toilet.

If you have questions regarding this form, please call the Health & Wellness Center at 585-385-8280. Thank you for your assistance.

The Health & Wellness Center at St. John Fisher College

St. John Fisher College Mental Health Disability Supporting Information Form

STUDENT INFORMATION

(Please Print Legibly)

Name (Last, First, Middle): _____

Date of Birth: _____ SJFC Student ID #: @ _____

Phone (best # to contact student): _____

Address: _____

City/State/Zip: _____

E-Mail address: _____

DIAGNOSTIC INFORMATION

(Please Print Legibly)

This form must be completed by a licensed mental health care provider qualified to do so (e.g. psychiatrist, psychologist, LMHC, etc.).

1. Date of diagnosis: _____

2. Date of student was last seen for this diagnosis: _____

3. DSM-IV diagnosis

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V (GAF Score): _____

4. In addition to DSM-IV criteria, how did you arrive at your diagnosis?

- Structured or unstructured interviews with the student
- Interviews with other persons
- Behavioral observations
- Developmental history
- Educational history
- Medical history

5. What is the severity of the disorder? Mild Moderate Severe

Please describe the severity indicated above:

6. What is the expected duration of this disability?

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7. Major Life Activities Assessment

Please indicate **the number** that best reflects the degree that the following life activities are affected.

Life Activity	0 - None	1-3 Mild	4-7 Moderate	8-10 Severe
Concentrating				
Thinking				
Memory				
Eating				
Social interactions				
Self care				
Regular attendance				
Keeping appointments				
Stress management				
Managing internal distractions				
Managing external distractions				
Sleeping				
Organization				
Other:				
Other:				

8. What specific symptoms does the student have that might affect her/his living in a residential setting?

9. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

10. Is this student currently receiving therapy or counseling? Yes No Not Sure

11. a. List medication(s) the student currently taking. How effective is the medication(s)? How might side effects, if any, affect the student?

b. Is the student compliant with the medication (s)? Yes No

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12. Describe the steps that the student has taken (or will take) to personally address her/his needs.

13. Please state specific recommendations regarding medical accommodations for this student, and a rationale as to why these accommodations are warranted based upon the student's **functional limitations**.

MENTAL HEALTH PROVIDER INFORMATION

Please fill in completely, sign and date

Provider Name (Print): _____

Title: _____

License/Certification #: _____

Address: _____

Phone Number: _____

Fax Number: _____

Provider Signature: _____ Date: _____