

**Physical Conditions Only**

**UNT Office of Disability Access (ODA) Physical Disability Documentation Form**  
*(To be completed by a Qualified Healthcare Professional)*

Student Name:

UNT Student ID number:

The above named student has requested reasonable accommodations based on a physical disability at the University of North Texas. To determine eligibility, the UNT Office of Disability Access requires documentation from a qualified healthcare professional (Medical Doctor, Nurse Practitioner, Physical/Occupational Therapist, etc.) not related to the student. This information will be used to determine eligibility for reasonable accommodations under the Americans with Disabilities Act of 1990 as Amended. Please provide the following information.

**Essential for all conditions: Will the student's disability create limitations lasting longer than six months?**      Yes      No

Name of Health Care Professional:

License #

Address:

Phone:

Please provide the ICD code and standard nomenclature for this student's diagnosis:

Date of Diagnosis:

Most recent date you examined/treated this student:

Is this student currently under your care?      Yes      No

If yes, how long?

**Blind/Low Vision Only (Attach most recent eye exam)**

Visual Acuity (best corrected) OD: \_\_\_\_\_ OS: \_\_\_\_\_ Vision Field (degree) OD: \_\_\_\_\_ OS: \_\_\_\_\_

Light Perception: OD: \_\_\_\_\_ OS: \_\_\_\_\_ Object Perception: OD: \_\_\_\_\_ OS: \_\_\_\_\_

Hand Movements: OD: \_\_\_\_\_ OS: \_\_\_\_\_ Counts Finger: OD: \_\_\_\_\_ OS: \_\_\_\_\_

Legally Blind: OD: \_\_\_\_\_ OS: \_\_\_\_\_ Eye fatigue issues: \_\_\_\_\_

Primary Means of reading text: Enlarged Font: \_\_\_\_\_ CCTV/magnifier Recommended Font size: \_\_\_\_\_

Other: \_\_\_\_\_

**Deaf/Hard of Hearing Only (Attach most recent audiogram)**

Hearing Loss in dB Right: \_\_\_\_\_ Left: \_\_\_\_\_

Certificate of Deafness: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Primary Communication Augmentation: Hearing Aid \_\_\_\_\_ Cochlear Implant \_\_\_\_\_ FM Loop \_\_\_\_\_

Sign Language \_\_\_\_\_

Please complete the following matrix which will be used to establish eligibility for reasonable accommodations. Attach any relevant medical records (eye exams, audiograms, sleep studies, functional capacity exams, etc.)

Students may still qualify for reasonable accommodations when the potential exists for a previously stable condition to worsen. Please complete the matrix to reflect those periods when the condition is ***not*** well controlled. Consider side effects of medications and other treatment(s) that may negatively impact life activities. Completion of this form has no bearing upon a student's future employability.

Life Activity Matrix	No Impact	Moderate Impact	Severe Impact	Don't Know
Speaking				
Hearing (attach recent audiogram)				
Seeing (attach recent eye exam)				
Lifting				
Standing				
Walking				
Sitting				
Manual dexterity/Writing				
Sleeping				
Concentration				
Memory				
Reading				
Caring for Self				
Class Attendance				
Bodily Functions (immune system, digestive, circulatory, etc.)				
Communication – Receptive				
Communication – Expressive				
Sustained Focus				
Eating				
Body Control				
Other				

Based upon the limitations noted above, please list recommendations for reasonable accommodations for this student.

By signing below, I am certifying that I or my designee has completed this form truthfully and accurately.

Signature and Professional Title: \_\_\_\_\_

Date: \_\_\_\_\_