DIVISION OF STUDENT AFFAIRS
Office of Disability Access

Medical Form for Student Request for COVID-19 ONLY Accommodations

To the medical practitioner: This student listed below has self-identified as your patient and has indicated that he or she is in a category identified by the Centers for Disease Control (CDC) as high risk for severe illness in contracting the COVID-19 virus due to an underlying medical condition. The student has requested modifications to the learning environment as a direct result of and for the duration of the COVID-19 health pandemic. Your assistance is appreciated in providing information to determine appropriate personal protective equipment (PPE), learning environment modifications, or specific suggestions to mitigate student risk of contracting the COVID-19 virus.

Patient Name: _____ Date of Birth: _____

1. Does this individual have an underlying health condition which places them at higher risk of severe illness in contracting the COVID-19 virus, as defined by the CDC? ☐ No ☐ Yes

2. If yes, please indicate the type of underlying health condition:
   _____
   _____
   _____
   _____

3. Describe any PPE and/or educational environment modification(s) that are required for the student to mitigate risk with respect to the COVID-19 virus. (e.g. face mask exemption, attendance flexibility, remote participation, etc.)
   _____
   _____
   _____
   _____
   _____
   _____

4. Are the modification(s) required solely for the purpose and duration of the COVID-19 health pandemic?
   ☐ Yes
   ☐ No (Explain) _____
   _____
   _____
   _____

5. What is the duration or expected duration of the required modifications?
   _____
   _____

6. Does this individual's health condition substantially limit any major life activities, as defined by the ADA/ADAAA?
   ☐ No
   ☐ Yes (Explain)* _____
   _____
   _____
   _____

*If yes, student must use the Physical Health Condition Documentation Form or Psychiatric Condition Documentation Form.

As defined by the ADAAA, 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.

Name of Medical Practitioner: _____ Phone: _____

Medical Practitioner's Signature: _____ Date: _____

Please return the completed form to the Office of Disability Access via email Apply.ODA@unt.edu or fax 940.369.7969.