



PROVIDER QUESTIONNAIRE FOR DISABILITY ACCOMMODATION HOUSING AND RESIDENCE LIFE

(Do not use this form to document the need for Emotional Support Animals)

Student's Name: _____ **DOB** _____

Phone: _____

By signing below, I consent to allowing my healthcare provider to share any information relevant to my need for an ESA as an accommodation, as shown on this form, with Disability Services for the next 60 days (about 2 months).

Student Signature: _____ **Date** _____

Dear Licensed Clinical Professional or Healthcare Provider:

The above-named student has requested that San Juan College consider providing an accommodation to provide equal access to housing. To properly evaluate the student's request, the Disability Services Office needs additional information from a licensed clinical professional or healthcare provider who is directly responsible for the treatment of the student's diagnosed disability. We ask that you please complete this form in its entirety, providing complete answers to all questions. If you are unable to provide a response to a question, please indicate the reason. It is not necessary to submit additional documentation for this student's request, however if you feel that additional information may provide a more complete understanding of the student's request you are welcome to submit it.

How to Submit:

Once this form has been completed it should be sent to Disability Services. The student can upload this form to their application, or it can be scanned and emailed DSO directly by the student or healthcare provider via the contact information below:

Disability Services Office Phone: 505-566-3271
San Juan College Fax: 505-566-4408
4601 College Blvd, Farmington, NM 87402
Email: disabilityservices@sanjuancollege.edu



PROVIDER QUESTIONNAIRE

1) Provide a description of the student's current diagnosis and disability-related symptoms. Please include frequency and duration of symptoms, if applicable.

2) The anticipated prognosis of the medical condition/disability:

- Permanent/chronic More than 6 months Short-term/temporary: 5 months or less
- Episodic: Expected duration: _____

3) Is the student currently under your care? Yes No

4) Date of most recent visit: _____

5) How long have you been working with the student regarding this diagnosis? _____

6) Does the student require ongoing treatment? Please explain.

- Yes: _____
- No: _____

7) Does the student's condition substantially impact a major life activity (e.g., seeing, hearing, eating, sleeping, walking, self-care, etc.) or bodily function (e.g., digestion, respiratory, circulatory, etc.)?

- No (please explain): _____
- Yes-If yes, please check only those areas of functioning and major life activities impacted by the student's condition, explain its impact on the identified areas/activities, and circle the level of severity.

Area of functioning/major life activities (check)	How is this area of functioning/major life activity impacted by the diagnosed condition?	Severity of limitation		
<input type="checkbox"/> Hearing		Mild	Moderate	Severe
<input type="checkbox"/> Vision		Mild	Moderate	Severe
<input type="checkbox"/> Speech		Mild	Moderate	Severe
<input type="checkbox"/> Walking		Mild	Moderate	Severe
<input type="checkbox"/> Sitting		Mild	Moderate	Severe
<input type="checkbox"/> Standing		Mild	Moderate	Severe



<input type="checkbox"/> Motor coordination		Mild	Moderate	Severe
<input type="checkbox"/> Self-care activities		Mild	Moderate	Severe
<input type="checkbox"/> Endurance		Mild	Moderate	Severe
<input type="checkbox"/> Respiratory		Mild	Moderate	Severe
<input type="checkbox"/> Cognitive functioning		Mild	Moderate	Severe
<input type="checkbox"/> Sleep		Mild	Moderate	Severe
<input type="checkbox"/> Eating		Mild	Moderate	Severe
<input type="checkbox"/> Social interactions		Mild	Moderate	Severe
<input type="checkbox"/> Other:		Mild	Moderate	Severe

8)What accommodations do you recommend in housing based on this student’s diagnosis and functional limitations?

9)In what ways will the proposed housing accommodations help to mitigate or alleviate symptoms and the impact of the student’s disability?

10) In your professional opinion, how important is it for the student’s well-being that these accommodations be provided in housing? What consequences, in terms of disability symptomology, may result if the accommodation is not approved?



Certifying Licensed Medical or Mental Health Professional

By signing below, you are verifying that you were solely responsible for completing this form, the information reflects your responses to the questions, you are treating this student, and are not a relative of the student.

Printed Provider Name: _____

Title: _____

Area(s) of Specialization: _____

State of Licensure/Certification: _____

License/Certification Number: _____

Phone Number: _____

Fax: _____

Provider Signature: _____

Date: _____