SAN JUAN COLLEGE

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 Accessibility 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 Accessibility 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 Accessibility Services. The student can upload this form to their application, or it can be scanned and emailed directly to ASO by the student or healthcare provider via the contact information below:

Accessibility Services Office Phone: 505-566-3271
San Juan College Fax: 505-566-3455
4601 College Blvd, Farmington, NM 87402
Email: accessibilityservices@sanjuancollege.edu

SAN JUAN COLLEGE

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:

   - o Permanent/Chronic
   - o More than 6 months
   - o Short-term/Temporary: 5 months or less
   - o Episodic: _____ Expected duration: _____

3) Is the student currently under your care?

   - o Yes
   - o 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?

   - o Yes
   - o No

   Please Explain: _____

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.)?

   a No (please explain): _____

   b 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.

SAN JUAN COLLEGE

Area of functioning/major life activities (check)	***How is this area of functioning/major life activity impacted by the diagnosed condition?***	***Severity of limitation***		
○ *Hearing*		Mild	Moderate	Severe
○ *Vision*		Mild	Moderate	Severe
○ *Speech*		Mild	Moderate	Severe
○ *Walking*		Mild	Moderate	Severe
○ *Sitting*		Mild	Moderate	Severe
○ *Standing*		Mild	Moderate	Severe
○ *Motor coordination*		Mild	Moderate	Severe
○ *Self-care activities*		Mild	Moderate	Severe
○ *Endurance*		Mild	Moderate	Severe
○ *Respiratory*		Mild	Moderate	Severe
○ *Cognitive functioning*		Mild	Moderate	Severe
○ *Sleep*		Mild	Moderate	Severe
○ *Eating*		Mild	Moderate	Severe
○ *Social interactions*		Mild	Moderate	Severe
○ *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?

SAN JUAN COLLEGE

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: _____