MOUNT CARMEL
College of Nursing

Healthcare Provider Form

Instructions: The purpose of this form is to gather information to assist the Mount Carmel College of Nursing Accommodations Coordinator to determine the extent of a student's disability and what accommodations may be appropriate. The information contained on this form is protected by FERPA.

Note: This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions. Once completed, this form should be submitted to Student Accessibility Services either by the student or directly from the healthcare provider using the contact information below:

Student Accessibility Services
Attn: Accommodations Coordinator
Mount Carmel College of Nursing
127 S. Davis Ave.
Columbus, OH 43222

Phone: 614-234-2341
Fax: 614-234-5979
Email: accessibility@mccn.edu

STUDENT INFORMATION (MCCN Student to Complete this Section)		
Name (Last, First, Middle Initial)		Phone (with area code) □ Cell □ Home □ Work
Student ID Number	Date of Birth	Campus & Program □ Main □ Fairfield □ Online □ BSN □ SDAP □ RN-BSN □ MS □ DNP

Release: I hereby authorize the healthcare provider listed below to release the information requested below to the Mount Carmel College of Nursing Accommodations Coordinator for the purposes of evaluating my request for academic accommodations.

Student: _____ Date: _____

QUALIFIED HEALTHCARE PROVIDER INFORMATION (Healthcare Provider to Complete this Section)	
Name: Credentials/Licensing: □ MD/DO □ PhD (Psychology) □ APRN □ LISW/LPCC/LMFT □ Other _____ Area of Certification/Board Certification: _____	Phone (with area code) _____ Fax (with area code) _____
Address:	Email:

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DISABILITY ASSESSMENT (Completed by the Qualified Healthcare Provider)	
1. What is the specific diagnosis/health condition? Please provide the relevant DSM-V or ICD-9/ICD-10 code:	
2. When was the diagnosis made?	3. When did you last see the student?
4. Does the student need to be re-evaluated on a regular basis for the condition? If yes, how often?	
5. How did you make the diagnosis? (Please describe the tests, methods, or diagnostic procedures used to make the diagnosis.)	
6. Describe the current symptoms of the diagnosis (es) that the student experiences. Describe the extent to which the student's condition(s) limit one or more major life activities. (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.)	
7. What is the current treatment plan? If applicable, list current medications and any side effects.	

By signing below, I certify that the information submitted here is accurate and that I am a qualified healthcare provider properly licensed and credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature: _____ Date: _____