UNIVERSITY of WASHINGTON
DISABILITY RESOURCES FOR STUDENTS

UW SEATTLE DRS HEALTHCARE PROVIDER FORM

Purpose of this Form
At the University of Washington-Seattle, Disability Resources for Students (DRS) approves academic and housing accommodations for students. Information provided on this form is only used to assist DRS in determining if this student's physical or mental health condition is a disability and what accommodations may be appropriate. For DRS' full documentation guidelines please visit depts.washington.edu/uwdrs/prospective-students/documentation-guidelines/.

The information provided to DRS on this form is protected by FERPA. To learn more about FERPA please visit www.washington.edu/students/reg/ferpa.html#Q2. If needed, the student can find a UW DRS Release of Information Authorization Form to complete at depts.washington.edu/uwdrs/wp-content/uploads/2016/07/Release-of-Information-Form-FILLABLE-FORM.pdf.

Instructions
Please legibly and thoroughly discuss the educational and/or housing effects of the stated disabilities in this form. This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated condition(s). This form should not be used to document learning disabilities or traumatic brain injuries. For our complete documentation guidelines please visit depts.washington.edu/uwdrs/prospective-students/documentation-guidelines/.

How to Submit
Once this form has been completed it should be submitted to DRS. The student can upload this form to their myDRS application or it can be turned into DRS directly by the student or healthcare provider via the contact information below:

Disability Resources for Students
University of Washington
011 Mary Gates, Box 352808
Seattle, WA 98195-2808

Phone: 206-543-8924
Fax: 206-616-8379
Email: uwdrs@uw.edu

STUDENT INFORMATION (UW Student Completes This Section)		
Name		Phone
Student ID Number	UW Campus	Date of Birth
HEALTHCARE PROVIDER INFORMATION (Healthcare Professional Completes This Section)		
Name:		Credentials and Licensing Information:
Address:		
Phone:	Fax:	Email:

DISABILITY ASSESSMENT
(To be completed by a qualified healthcare provider)

1. What is the specific diagnosis/health condition? Please also provide the relevant DSM-V or ICD code.

2. When was the diagnosis(es) made?

3. When did you last see the student?

4. Do the symptoms of the diagnosis(es) need to be reevaluated on a regular basis? If yes, how often?

5. Please describe the current symptoms of the stated diagnosis(es) this student experiences. *Example: Student's dominant wrist is immobilized.*

6. If the student experiences episodic flare-ups of their condition please describe any triggers of episodes, the frequency and duration of episodes, and care plan for management/recovery of the episode.

DISABILITY ASSESSMENT (CONT.) (To be completed by a qualified healthcare provider)
7. How does the diagnosis(es) significantly affect the student's performance in academic settings?
8. How does the medication and/or treatment plan significantly affect the student's performance in academic settings?

By signing below I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature:_____

Date:_____

If the student needs mobility or housing related accommodations, please fill out the "Mobility Assessment" and "Housing Assessment" pages below.

MOBILITY ASSESSMENT SUPPLEMENT

(Complete only for conditions affecting student's ability to access physical spaces)

9.A. Is the student able to climb or descend stairs? (check one)

- ◯ Yes
- ◯ Yes, with limitations
- ◯ No

9.B. Does the student have difficulty walking? If so, please elaborate on limitations, distance they are able to transport themselves, etc.

10. Does the student use any assistive mobility devices (e.g. wheelchair, crutches, cane, etc.), personal attendant, or service animal? If so, please list all applicable.

11. Does the student have a current need for ergonomic or facility modifications (e.g. adjustable desk, adjustable chair, sit/stand desk, podium, grab bars (shower/toilet)).

By signing below I am verifying that the transportation/parking information provided above is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the conditions necessitating the need for transportation/parking accommodations.

Healthcare Provider Signature:_____ **Date:**_____

HOUSING ASSESSMENT SUPPLEMENT (Healthcare Professional Completes This Section. Complete only for conditions affecting student's ability to access residential spaces.)
12. How does the diagnosis(es) significantly affect the student's access in the living environment? (e.g. This student uses a wheelchair and will need access to a roll-in shower.) Please state specific needs (Hoyer lift, single room, visual fire alert, etc.) of the student.
13. Emotional Support Animal (ESA) specific: **13.A**. Is it your recommendation that this student be approved for an ESA in the residential setting? Please elaborate on your reasoning.
13.B. What are the symptoms the student experiences and how does the animal help mitigate those symptoms in a residential setting?

By signing below I am verifying that the transportation/parking information provided above is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the conditions necessitating the need for transportation/parking accommodations.

Healthcare Provider Signature:_____ **Date:**_____