ADA Participation & Accomodation Request Form

ADA Participation & Accomodation Request Form Overview

Student Instructions

Student shall contact their treating health care provider to complete this form. Student should return the completed form to DisabilityServices@unitek.com

Please contact your Campus ADA Coordinator for any questions.

Health Care Provider Instructions

Health care provider shall complete sections 1 and 2 of the form including provider signature and information.

To:

RE:

Applicant's Program of Interest:

Tentative Program Start Date:

Campus Name:

Healthcare Provider Section 1

Please complete all information in this section.

1. Does this person have a physical or mental impairment that limits one or more major life activity? A physical or mental impairment "limits" a major life activity if it makes the achievement of the major life activity more difficult.

Yes

No

If the answer is no, **stop**, no further information is required. If the answer is yes, proceed to question two.

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2. Based on your answer of yes to question one, please identify the major life activity or activities that is/are limited:

Walking

Reaching

Speaking

Communicating

Breathing

Concentrating

Seeing

Climbing Ladders and Getting on Roofs

Standing

Lifting

Learning

Sleeping

Caring for Oneself

Socializing

Working

Performing Manual Tasks

Sitting

Hearing

Reading

Thinking

Other

3. Is the condition in question 2 permanent or temporary? Please explain.

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4. If temporary, when would it reasonably be expected to no longer limit a major life activity?

Healthcare Provider Section 2

Please complete all information in this section.

1. Is the person able to perform the essential functions of the educational program the person is applying to?

Yes

No

If yes, **stop**, no further information is required.

If no, what essential functions cannot be performed?

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2. Can this person perform the essential functions of the educational program with "accommodations"?

No

Yes

If no, **stop**, no further information is required.

If yes, please list the examples of reasonable accommodations which may enable this person to perform the essential educational program participation functions (i.e. extended testing times, separate room for testing, etc.)

Signature of Healthcare Provider:
Office Name and Practice Type:
Office Address:
Office Telephone Number:
Date: