



MEDICAL DOMAIN

PATIENT INFORMATION

(Please complete the relevant information and submit to your provider for completion)

Name: Date:
Last
First
Middle Initial

Medical Condition Requiring Accommodation:

Date of Birth: People Soft Number:

Status (check one): Student Staff Faculty Other (explain)

Contact Phone Number:

University E-Mail Address: @pitt.edu

Mailing Address:

Please identify, for your treatment provider, the accommodations you are requesting from the University of Pittsburgh.



MEDICAL DOMAIN

PROVIDER: PLEASE COMPLETE
 (Please type or print legibly)

The above named individual is requesting accommodations from the University of Pittsburgh. The University of Pittsburgh, for the purposes of establishing a disability and determining reasonable accommodations, requires current information about the condition. The information submitted will be examined in an individualized case-by-case inquiry, specifically looking at the impact of the condition on this individual and within the specific context of the requested accommodations.

Name: _____ Date: _____

License or Certification #: _____

Mailing Address: _____

Phone Number: _____

1. Describe your professional credentials.

2. Provide a diagnosis or diagnoses.

3. Is this individual currently under your care for the above mentioned condition? Yes No



University of Pittsburgh
at Greensburg
Learning Resources Center

Millstein Library Building, Room 240
150 Finoli Drive
Greensburg, PA 15601-5898
724-836-7098, TTY: 724-836-7128
Fax: 724-836-7493
E-mail: los3@pitt.edu

4. Establish the extent to which the medical condition currently impairs this individual. Include severity, frequency, and pervasiveness of this condition at the **present time**. Identify major life activities that are affected. (This information will be used by qualified personnel at the University of Pittsburgh to determine if the individual's requested accommodations are reasonable.)

5. Describe how the condition is currently being treated or managed.



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7. For individuals with low vision impairments, please identify best corrected visual acuity.

8. For individuals with brain injuries, please submit comprehensive neuropsychological evaluation and/or include probable site of lesion.

9. For individuals with hearing impairments, please submit a current audiogram.

Signature: _____ Date: _____

Please mail or fax to:
Dr. Lou Ann Sears
University of Pittsburgh at Greensburg
150 Finoli Drive
Greensburg, PA 15601-5898
724-836-7098, TTY: 724-836-7128
Fax: 724-836-7493

OR

Scan and e-mail as a PDF to: E-mail: los3@pitt.edu