St. Vincent’s College Disability Office
Provider Information Form

Date:

Regarding (Name of Student):

Dear Provider,

Your patient (the student named above) has applied for admission to or has enrolled in the ____________ program at St. Vincent’s College (the “College”), and has informed the College that he or she has a disability. We need your input and assessment to help us determine whether he or she can safely participate in this program, and whether he or she may need some reasonable accommodation based on a disability to provide full access to the educational environment. Some accommodations may be appropriate for the classroom setting while others may be utilized in the clinical area. Listed below are examples of requirements for the College’s educational programs (more related to clinical activities) that students need to meet with or without accommodations. Please address these requirements in providing your evaluation of whether the student can meet the requirements without posing a safety risk to himself or herself or others. In addition, we would also appreciate any recommendations for accommodations, adaptive devices, assistive services, compensatory strategies, and/or collateral support services.

General
Applicant/Student must be capable of doing the following:

- Work effectively independently; and in small or large groups as part of a team
- Focus attention on task

Psychomotor
Applicant/Student must have sufficient physical abilities, manual dexterity and visual acuity to accomplish the following:

- Use appropriate body mechanics, use appropriate equipment to lift patients
- Manipulate objects with fingers
- Safely use sharp instruments
Intellectual
Applicant/Student must have sufficient intellectual ability to perform the following tasks:

- Process verbal and written instructions
- Be able to read, understand, and comply with written protocols

1) What is the nature of the student’s disability (diagnosis):

___________________________________________________________________________

2) Do you have any concerns about this student’s ability to participate in this program without posing a safety risk to her/himself or others?

___________________________________________________________________________

3) What accommodations, if any, do you recommend for this student to meet the program requirements in the classroom and/or the clinical setting?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

4) What is the anticipated duration of the patient’s disability:

___________________________________________________________________________

5) How long have you been the student’s treating physician for this disability:

___________________________________________________________________________

6) Please provide any additional information you believe would be important and/or helpful:

___________________________________________________________________________

___________________________________________________________________________
Provider Name (please print) Address, and telephone number:

Name –
Address –
Telephone - Fax -
License or certification number –
Specialty –
Date of last exam/appointment with client -

__________________________________ __________________________
Provider Signature Date

Please complete the form and return via USPS to:
  Kirk Lynch, Interim Disability Coordinator
  St. Vincent’s College
  2800 Main Street
  Bridgeport, CT  06606

Or scan the document to:  kirk.lynch@stvincentscolorlege.edu

If you have any questions regarding this form/request, please contact me at 203-576-6411.

Sincerely,

Kirk Lynch II, M.S.
Interim Disability Coordinator

To be eligible for services, your client must have a disability as defined by Section 504 or the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 and Amendment of 2009. These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one of more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. “Major life activities” are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one’s self, performing manual tasks, and functions including but not limited to, the immune system, bladder, bowel, respiratory, circulatory, and endocrine systems.