HARVARD LAW SCHOOL | Accessibility Services

Statement from Medical Provider

StudentInformation

Name: _____ Date: _____

Date of Birth: _____ HUID: _____

FortheMedicalProfessional

This form is intended to be used for determining the purpose of appropriate accommodations for a student requesting disability or medically-related accommodations at Harvard Law School. Please complete the requested information in as much detail as possible. The information obtained will be used for the sole purpose of determining appropriate accommodations. Please feel free to contact Accessibility Services in the Human Resources Office with any questions. Completed forms can be submitted via email to accessibility@law.harvard.edu, faxed to 617-812-4677, or sent in the mail to Accessibility Services Harvard Law School, 1585 Massachusetts Ave., Suite 010, Cambridge, MA 02138.

Provider'sInformation

Medical Professional's Name: _____

Certification/Credentials: _____

State Licensure and Number: _____

Agency or Institution Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Signature: _____ Date: _____

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Diagnostic Information

Specific diagnosis(es) related to the accommodations request:

_____

_____

_____

_____

_____

Date of diagnosis or date of onset: _____

Most recent evaluation or visit: _____

How long is this condition likely to exist? _____

Please describe the student's functional limitations related to the diagnosis:

_____

_____

_____

_____

If applicable to the requested accommodations, please list any current medications and potential side effects related to the functional limitations:

_____

_____

_____

_____

Please list the recommended academic accommodation(s) and rationale for each accommodation:

_____

_____

_____

_____