LSU

Sponsoring Unit

Program Participant Accommodation Request:

PROVIDER FORM

Section 1. Requestor Information: **TO BE COMPLETED BY REQUESTOR**	
Requestor Name:	**Requestor Email:**
Program/Event in which I plan to participate:	**Requestor Phone:**
Date and Time of Program/Event:	**Name of University Dept. Hosting Event:**

Section 2. Medical Information: **TO BE COMPLETED BY HEALTHCARE PROVIDER**
For reasonable accommodation under the ADA, an individual has a disability if one has an impairment that substantially limits one or more major life activities or a record of such impairment. The following questions may help determine whether an individual has a disability and what accommodation is needed to afford equal access:
History:
Does the requestor have a disability that substantially limits a major life activity as compared to most people in the general population? **If yes, what is the nature of the limitations?**
Diagnosis:

When did the symptoms first appear (Date & Year)?

Date Requestor was last seen by healthcare provider (MM,DD,YY):

Recommended Accommodation(s):

☐Temporary

☐Permanent

Would the recommended accommodation enable the patient to participate in this program or activity?

[ ]Yes

[ ]No

Section 3. Comments Not Otherwise Addressed

Section 4. Signature

Healthcare Provider's Name: ______________________________**Date:** ____________

Phone #: ____________________**Street Address:** ______________________________

City: ______________________ **State:** _____________**Zip Code:** _________________

Healthcare Provider's Signature: ____

Please return form to Louisiana State University, insert sponsoring unit name, contact person in unit for program or activity, physical/mailing address, email address, phone and fax.