PART II: HEALTH CARE PROVIDER'S STATEMENT

Each treating practitioner must complete the Health Care Provider's Statement and return it along with all supporting documentation to the patient/student. Please type or print the requested information, unless a signature is required.

Health Care Provider Name:

Professional Title:

Professional training, credentials, licensing, and specialization to support relevant diagnoses and appropriate accommodation recommendation:

Office Address:

Telephone Number:

State License Number:

Patient's Name:

Patient's Address:

Date Patient First Consulted:

Date Patient Last Consulted:

Number of Years as a Patient:

Diagnosis of Disability:

Recommended Accommodation(s):

I. Please attach a written statement explaining the diagnosis and its impact on the candidate's abilities relative to the request for each accommodation. *(To ensure that a current diagnosis is presented, it is preferred that the evaluations have been conducted within the past three to five years. Please provide an explanation of any gaps in medical evaluations taking place prior to the request for accommodation.)*

II. Please attach a written explanation for each recommended accommodation, including the current treatment for the disability (e.g., any medication management or physical aids, etc.). Any current and applicable test used to support the diagnosis or recommendation for accommodations should be submitted.

III. If no accommodations were provided to the candidate in the past, please provide a written explanation of why accommodations are requested now and why they were not requested in the past.

Certification I hereby certify that the information that I provide pursuant to this Health Care Provider Statement is true and correct and is provided pursuant to the authorization to release information signed by my patient. I further certify that I have the necessary specialized training to make the diagnosis herein, that I personally examined the candidate named herein, and that I used my professional judgment to render the diagnosis herein and assess the accommodation request. I acknowledge that Appalachian College of Pharmacy may contact me, pursuant to the patient/student's permission to obtain further information if necessary.

Practitioner's Signature: Date: