UNIVERSITY of WASHINGTON
HUMAN RESOURCES
Disability Services Office

UW DSO Health Care Provider Form

AUTHORIZATION FOR INFORMATION (UW Student Completes This Section)		
Name (Last) (First) (M. I.)		Phone
Student ID Number	UW Campus	Date of Birth
Name of Health Care Provider		Health Care Provider's Phone
Health Care Provider's Address		

I hereby authorize the above-named health care provider to complete this form and disclose to University of Washington and its authorized representatives the following information related to my health care: the diagnosis (es) of relevant conditions, treatment plan(s), my ability to perform in the educational setting, recommendations, history, reports and correspondence.

I understand that it may be necessary for the university representatives to share this information for purposes related to accommodation of a disability. I authorize the university to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process. My health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) behavioral or mental health services, and treatment for alcohol and drug abuse.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained separate from my personnel file. This authorization is valid for 90 days after the date of my signature below. However, I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the above-named health care provider will not condition treatment or payment based on receipt of this signed authorization.

I hereby authorize my health care provider to discuss directly with university representatives any medical/mental health information relevant to my accommodation request. By signing this page, I acknowledge that I have read and agree to the terms described above. (NOTE to Student: If you do not provide authorization for your health care provider to discuss the medical/mental health information relevant to your accommodation request, processing of your accommodation request may be delayed.)

Student's Signature:	Date:

DISABILITY ASSESSMENT (To be completed by a qualified healthcare provider)	
Please read before completing: A disability is any physical or mental impairment that substantially limits one or more major life activities. The purpose of this form is to gather information to assist Disability Services Office (DSO) in determining if this student's physical or mental health condition is a disability. This information also helps DSO determine the student's eligibility for accommodations. *Note: This form should not be used to document learning disabilities or traumatic brain injuries.*	
What is the specific diagnosis/health condition? Please provide the relevant diagnostic code if applicable (e.g. DSM-V).	
When was the diagnosis (es) made?	When did you last see the student?
Please describe the anticipated duration of the condition in months or indicate "chronic" if applicable.	
What is the current treatment plan? If applicable, please describe current medications and their side effects.	
How does the diagnosis affect the student's ability to learn, participate in, or access university environments (i.e. the classroom (in-person or online), university housing, etc.)? *Example: Student cannot write due to a broken dominant wrist.*	

Do you have any specific recommendations for relevant accommodations? *Example: Please allow student a computer to type responses.*

UW DSO Disability Transportation/Parking Evaluation
(Complete only for transportation/parking accommodations)

A. Student can negotiate curbs: ☐ Yes ☐ No

B. ☐ **Student is not able to climb or descend stairs of any grade.**
☐ **Student is able to use stairs at the checked grades:**

Stairs/Grade	5%	10%	15%	20%
1 to 4				
5 to 10				
11+				

C. Student can transport himself/herself:

- ☐ less than 200 feet
- ☐ 200 feet to 400 feet
- ☐ 400 feet to 600 feet
- ☐ 600 feet to 800 feet
- ☐ 800 feet to 1000 feet or more

½ block = 200'
1 block = 400'-500'
3 football fields = 1083'

D. Student uses: ☐ Wheelchair: ☐ manual ☐ motorized ☐ crutches ☐ scooter ☐ cane ☐ service animal ☐ other _____

E. Student:

- ☐ is blind or visually impaired
- ☐ is able to enter and exit vehicles unassisted
- ☐ has a height of ____inches when seated in wheelchair
- ☐ requires an attendant
- ☐ fatigues easily
- ☐ other _____

HEALTHCARE PROVIDER INFORMATION	
Name:	Credentials and Licensing Information:
Address:	
Phone: Fax:	Email:
Signature:	Date:

Instructions for student and/or healthcare provider:
Once this form has been completed it should be submitted to DSO. Either the student or the healthcare provider may submit the form directly to DSO via the contact info below:

Disability Services Office
University of Washington
4300 Roosevelt Way NE
Roosevelt Commons West, 2nd Floor
Box 354960
Seattle, WA 98105-4960

Phone: 206-543-6450
Fax: 206-685-7264
Email: dso@uw.edu