IOWA STATE UNIVERSITY EXTENSION AND OUTREACH
HEALTH CARE PROVIDER DOCUMENTATION OF DISABILITY FORM

All Extension users with qualifying disabilities requesting accommodations, or auxiliary aids from (insert county name) County Extension and Outreach are required to submit documentation of their disability to the Extension office to verify eligibility under the Americans with Disabilities Act Amendments Act (ADAAA of 2008), Americans with Disabilities Act (ADA of 1990), Section 504 of the Rehabilitation Act of 1973, and/or (insert county name) County Extension and Outreach policies. It is strongly recommended that Extension users initiate a request for services and/or reasonable accommodations no later than 30 days prior to the event to assist the (insert county name) County Extension office in determining eligibility for reasonable acommodations (see below). Appropriate documentation must be on file with (insert county name) County Extension and Outreach before eligibility determination and/or discussion related to accommodation requests can be completed.

Complete Section 1 below and have the physician or care provider complete Section 2 and submit the **Documentation of Disability** form to (insert county name) County Extension and Outreach office.

Section 1: To be completed by Extension user/youth's legal guardian:

_____ _____
Extension User's Name Guardian's Name (if needed)

_____
Date

Release of Information
I hereby authorize the release of the following information to (insert county name) County Extension and Outreach for the purpose of determining the availability of reasonable special accommodations. I further authorize (insert county name) County Extension and Outreach to seek clarification of this documentation if necessary by contacting my physician or health care provider. I acknowledge additional medical release information may be required by my health care provider.

_____ _____
Extension User's or Guardian's Signature Date

Section 2: To be completed by the physician or health care provider:

To Physician or Health Care Provider:
To request reasonable and appropriate accommodations, families must provide current documentation of a disability. Federal and state law define a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having any impairment. As the Extension user's physician or health care provider, you are asked to complete all sections of this form. Additional information may be attached if necessary. Consistent with the Genetic Information Nondiscrimination Act, family medical history, genetic information, or genetic services history should not be provided.

Thank you for your assistance. Form to be completed by Extension user/youth's guardian and physician or health care provider. Please return to (insert county name) County Extension and Outreach.

Page 2, Section 2 **Extension User's Name:** _____

1. Please identify the patient's physical or mental impairment:
   _____
   _____
   _____

2. Please describe the duration of this impairment (check the appropriate box):
   ☐ long-term ☐ short-term ☐ permanent ☐ recent
   Explanation (if necessary): _____
   _____

3. Please describe the effects or limitations this impairment has on the patient's activities, if any:
   _____
   _____
   _____
   _____
   _____

4. Are there any activities or situations that should be avoided or that would present a health or safety risk to this client or others due to the impairment?
   ☐ Yes ☐ No
   Explanation (please provide): _____
   _____
   _____
   _____

5. Other comments concerning this impairment:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

(Attach additional information if necessary)

Thank you for your assistance in providing this information so that we may assess the special accommodations request. Please sign below.

_____ _____

Signature of physician or care provider **Date**

_____

Provider name (printed)