

Health Care Provider Disability Verification Form

All Iowa State University Extension and Outreach county users with qualifying disabilities requesting accommodations, or auxiliary aids from ISU Extension and Outreach _____ County are required to submit documentation of their disability to the county 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 ISU Extension and Outreach _____ County office policies. ISU Extension and Outreach _____ County recognizes that accommodations may be requested orally, and/or in person, and up to the date of the event. However, the timing and manner of a request potentially reduces the county extension office's ability to determine a reasonable accommodation. In that context, it is strongly recommended that county extension users initiate a request for accommodations, using this form and the Accommodation Request form, no later than 30 days prior to the event by filling out this form to assist the ISU Extension and Outreach _____ County office, in determining eligibility for reasonable accommodations (see below). If the county extension user requires assistance in filling out these forms that may also be requested.

Complete Section 1 below and have the physician or health care provider complete Section 2 and submit this **Disability Verification** form to ISU Extension and Outreach _____ County office.

Section 1: To be completed by county 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 Iowa State University Extension and Outreach _____ County, in order to determine the availability of a reasonable special accommodation. I further authorize Iowa State University Extension and Outreach _____ County 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. A disability requiring an accommodation under federal or state law can be either a physical or mental impairment or a record of such an impairment which substantially limits one or more major life activities. As the ISU Extension and Outreach _____ County office 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 county extension user/youth's guardian and physician or health care provider. Please return to ISU Extension and Outreach _____ County.

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

2. Please describe the expected duration of this impairment (check the appropriate box):

long-term short-term permanent intermittent

Explanation (if necessary): _____

3. Please describe the effects or limitations this impairment has on this patient's day-to-day 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

How likely is the occurrence of a health or safety risk? If it does occur, how significant of a risk is it to the patient:

5. If there are activities or situations that present a health or safety risk, are there measures that can be taken to remove this risk?

Explanation (if necessary):

6. 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 health care provider

Date

Provider name (printed)