Student Affairs
Midway University
512 E. Stephens St.
Midway, KY, 40347

Student Information:

Name:_____ Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Email:_____Student ID: _____

I hereby authorize _____to release/discuss the information below.

Signature of Student:_____Date:_____

If above student is a minor (under the age of 18) please have them feel out the authorization below.

I hereby authorize _____to release/discuss the information below.

Signature of parent/guardian:_____Date:_____

The Accommodations Coordinator facilitates and assists qualified students with documented disabilities, as defined by the ADA, to receive reasonable accommodations. Accommodations are determined on an individual basis based on a review of the submitted documentation from a medical professional and any information gathered from the student. If the submitted documentation from a qualified healthcare professional does not support the requested accommodations, the requested may be denied or additional documentation may be required.

This form may be sent via secure email HERE to the Student Accommodations Coordinator or you may fax it to 859-846-5399.

DIAGNOSTIC INFORMATION
(to be completed by medical practitioner/specialist)

1. Please state whether the student has a current disability that substantially impairs the student in one or more major activities.

_____
_____
_____
_____

Duration of condition: ☐ Permanent ☐ Temporary (specify length of time)_____

Date of Diagnosis:_____ Date of last contact with student:_____

2. Please describe any major activities impacted by the disability or symptoms that may need to be addressed in the college environment, and any specific recommendations for accommodations:

_____
_
_____
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HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon written request.

Provider Name (PRINT): _____

Provider Signature: _____ Date: _____

Title: _____

License or Certification #_____ National Provider Identifier (NPI): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____