Office: HK 104
Phone: 402-554-2872
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unoaccessibility@unomaha.edu

DISABILITY EVALUATION

First Name:____________________________________ Last Name: ____

NU ID: ____ Date of Birth: ____

UNO Major/Program: ____

I have reviewed the medical status of this student. I have conducted an exam for the purpose of assessing whether the student has a physical, psychological, sensory, or learning disability, the impact of said disability, if any, on major life activities, and which accommodations may be reasonable concerning the student's ability to participate in their academic program or an activity at the University of Nebraska at Omaha. The answers provided below, and any additional statements made, reflect my medical judgment concerning the status of this student.

1. Have you diagnosed this student with a disability? _____ Yes _____ No

   If yes, please provide a detailed diagnosis:

   ____

   ____

   ____

   ____

2. What functional limitation(s) is/are interfering with the student's ability to participate in the program or activity at issue?

   ____

   ____

   ____

   ____

3. Which aspect(s) of the program or activity at issue is/are the student unable to perform because of the limitation(s)?

   ____

   ____

   ____

   ____

4. Do you know of any accommodation(s) that might help the student participate effectively in the program or activity at issue? _____ Yes _____ No

   If yes, please explain the nature of the recommended accommodation(s) in detail:

   ____

   ____

   ____

   ____

5. Does the student have any physical or mental impairment that would create a current, significant risk of serious harm to themselves or others if they participate in the program or activity at issue? _____ Yes _____ No

   If yes, please explain in detail:

   ____

   ____

   ____

   ____

6. In considering whether the student poses a significant risk of serious injury or death to themselves, I have considered the following:
   a. The severity of harm _____ Yes _____ No
   b. The likelihood of an accident or other cause of harm occurring _____ Yes _____ No
   c. The imminence of the potential harm (not just a speculative risk) _____ Yes _____ No

Please print or type:

Provider Name: ____

Title or Professional Designation: ____

Highest Academic Degree: ____

Board Certification or Specialty: ____

Complete Address: ____

Phone: ________________________________ Fax: ________________________________

Email: ________________________________

Signature of Provider: ____ Date: ____________________