

[Medical Provider Letterhead] [Provider's Name] [Provider's Address, Email and Phone Number] [Date]

RE: DOCUMENTATION FOR REASONABLE ACCOMMODATION

I am writing this letter on behalf of my patient, [Patient's Full Name], who is under my care for treatment. It has come to my attention that [he/she/they] requires housing accommodations to address [his/her/their] medical condition and ensure [his/her/their] ability to be successful at Principia College.

Patient Information: Full Name: [Patient's Full Name] Date of Birth: [Patient's Date of Birth] Diagnosis: [Patient's Diagnosis] Treatment Plan: [Brief description of treatment plan]

I have conducted a thorough evaluation of [Patient's Full Name]'s condition and have determined that [he/she/they] would benefit from specific accommodations to minimize any functional limitations and ensure equal opportunities. I understand that it is essential to engage in an interactive process to determine the most appropriate accommodations based on the individual's needs and the nature of the job.

Based on my professional opinion and the medical information available to me, I recommend the following reasonable accommodations for [Patient's Full Name]:

[Accommodation #1]: Provide [details of accommodation] to enable [Patient's Full Name] to [details about how the accommodation would help the patient].

[Accommodation #2]: Consider [details of accommodation] to enable [Patient's Full Name] to [details about how the accommodation would help the patient].

[Accommodation #3]: Implement [details of accommodation] to enable [Patient's Full Name] to [details about how the accommodation would help the patient].

I believe that these accommodations would enable [Patient's Full Name] to be successful at Principia College while managing [his/her/their] health condition effectively. If you have any concerns or questions regarding these accommodations, please do not hesitate to contact me directly.

I am available to discuss this matter further or provide any additional documentation or clarification required. Please consider these accommodations in accordance with the Americans with Disabilities Act (ADA) and other applicable laws and regulations.

Thank you for your attention to this matter.

Sincerely,

[Medical Provider's Full Name] [Medical Provider's Title and Medical
Credentials/License] [Medical Provider's Contact Information]