Pregnancy or Pregnancy-Related Documentation Form

Utah Valley University is committed to nondiscrimination, diversity, and inclusiveness of all individuals. This form is to be used when a student is seeking accommodation because of their pregnancy or pregnancy-related condition conflicts with their school environment.

This form may be returned to the student or submitted directly to Utah Valley University Accessibility Services:
Email: accessibilityservices@uvu.edu **Fax**: 801-86-8377,
Physical Mail: Utah Valley University, Accessibility Services, 800 W. University Parkway, Orem, Utah, 84058

For questions, please contact UVU Accessibility Services at 801-863-8747 or accessibilityservices@uvu.edu

Student Information (to be completed by student)

Student Name:	
Student ID Number:	Phone Number:

Release of Information

By signing below, I hereby request and authorize the physician or medical provider listed on this form to furnish and/or discuss with Utah Valley University's Accessibility Services Department any information in their possession that provides a diagnosis and/or description of associated functional limitations and capabilities, as well as any information related to previous or current recommended accommodations/academic adjustments.

Student Signature:	Date:

Medical Provider Information

	Email:
Institution:	Phone:
Credentials (specialty, license, certification):	

Medical Information (to be completed by a licensed/certified professional):

Anticipated Due Date (or date of baby's birth):	Or date(s) of medical condition/event:
Please describe any complications or conditions caused by the pregnancy (i.e., Gestational diabetes, hyperemesis gravidarum, miscarriage, etc.):	
Recommendations for accommodations:	
Recommendations for post-partum recovery:	
Please include any additional information that will assist us in determining accommodations that will provide access to an academic environment:	

By signing below, I verify that the diagnosis(es) and supporting information are accurate and current and that I am a qualified professional, certified/licensed to provide medical care for the stated pregnancy or pregnancy-related condition.

Medical Professional Signature:	Date: