Office for Student Access
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Disability Documentation Form

Student's Name: _____

Diagnoses and Tests Performed

Please provide a diagnostic statement identifying the impairment/condition for which you have or are currently treating the student. *When appropriate this should include International Classification of Diseases (ICD) or Diagnostic Statistical Manual (DSM) codes. Only diagnoses related to the accommodation requests (conditions which impact the student in the educational environment) need to be listed.*

Diagnosis(es): _____

Date of diagnosis(es): _____ Date first seen:_____

Number of visits related to condition(s): _____ Date of most recent visit: _____

Is this condition permanent? ☐ Yes ☐ No Expected duration of condition(s): _____

Additional Notes:

What measures were used to identify the diagnoses(es)? *Please provide a copy of any relevant test results (i.e. audiogram, vision report, psychoeducational evaluation). A complete medical record is not necessary.*

If the student is currently undergoing treatment or taking medication please list any relevant side effects. *Only side effects related to the accommodation request (which impact the student in the educational environment) need to be listed.*

Recommended accommodations

Please describe the accommodations, auxiliary aids, or services that you recommend to facilitate equal access to learning environments and/or student activities. Please include recommended accommodations for learning environments outside a traditional classroom if applicable (i.e. labs, clinical, practicums, internships).

Major Life Activities

In order to qualify for academic accommodations: A student must meet the definition of disability which means they have a physical or mental impairment that substantially limits one or more major life activity. Additionally, there should be a link between a link between the functional limitations of the condition(s) and your recommended accommodations.

Please initial the major life activities impacted at the level of limitation due to the condition(s) diagnosed and described above.

Major Life Activity	Mild	Moderate	Substantial	N/A or Unknown
Breathing				
Speaking				
Seeing				
Hearing				
Sleeping				
Eating				
Reading				
Learning				
Thinking/Concentrating				
Fine Motor Control				
Lifting				
Walking/Climbing Stairs				
Standing				
Sitting				
Function of a Major Bodily Functions				
Fatigue				
Expressive Skills				
Receptive Skills				
Handwriting				
Interacting with Others				
Activities of Daily Living				
Other:				
Other:				

Additional notes/supporting information:

Certifying Qualified Licensed Professional

I, the undersigned, certify that I am a qualified licensed professional with expertise in the diagnosis of the above documented impairments or conditions and made the diagnoses following established practices in my field. I certify that I am the professional responsible for determining the diagnosis and/or treating the student for the impairment/condition identified above. I also certify that the information contained in this form was written by me; and that this information is an accurate description of their diagnosis and functional limitations.

_____ _____

Printed Name and Title Date

_____ _____

Signature Phone Number