University’s programs and services. Federal law defines a disability as “a physical or mental impairment that substantially limits one or more major life activities.” Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that learning, to allow us to

oals. Persons who wish to receive accommodations due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the person’s condition, must have experience diagnosing and treating condition, and will be an impartial professional who is not related to the patient. NOTE: Form may not be used as documentation for Assistance Animals. Please complete all blanks on this document. If any information is left unanswered, this documentation will not be accepted.

The Americans with Disabilities Act (ADA) defines disability as “a physical or mental impairment that a

Client Information (to be completed by the client)

Last Name: _____ First _____ Middle Initial _____

Date of Birth: _____ o] vš µ ^ v š / #: _____

Certifying Professional (to be completed by the certifying professional)

Certifying Professional's Full Name: _____

Credentials/Specialization: _____

License Type:

_____

License #: _____ State _____ Exp. Date _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Area Code: (_____) Phone Number _____

Fax Area Code: (_____) Fax Number _____

Email: _____

Office web address: _____

Diagnosis/Diagnoses: Please include DSM or ICD Codes and name of condition(s)

Date of onset: _____ Date of diagnosis: _____

Diagnostic Tools: How did you arrive at your diagnosis/diagnoses? Please check any relevant items below and attach assessment(s) to this form:

- ☐ Interviews with the client
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Psycho-educational testing
- ☐ Neuro-psychological testing
- ☐ High School IEP/504 Plan
- ☐ Self-rated or interviewed related scales
- ☐ Other

Prognosis

Expected Dura

☐

Medication, Treatment, and Prescribed Aids

What medication(s) are currently being used to address the diagnosis/diagnoses above? Fully describe impact of medication side-effects that may adversely affect the client's academic or workplace performance.

What treatment and prescribed aids (i.e. counseling, therapy, support groups) are currently being used to address the diagnosis/diagnoses above?

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please o25 T]TJ -0-1 (y)]TJ -3T833 2.8.(pa)D (Dat0.334 Tw 3)Tj -0.324 Tw (c)Tj -o.012 Tw (no,)T0.2

Implications for Workplace or Academic/Student Life

Major Life Activity	Explanation of Impact Please describe the impact of your client's condition as it applies to each major life activity	Recommendations for Accommodations and Services Please provide specific recommendations to address impacted major life activities
Concentration		
Long Term Memory		
Short Term Memory		
Sleeping		
Eating		
Social Interactions		
Self-Care		
Managing Internal Distractions		
Time Management		
Motivation		
Stress Management		

Using the contact information on page one, print, sign below, and fax/send directly to Disability Support Resources.

Date: _____

Certifying Professional Signature: _____

Signature denotes content accuracy, adherence to professional standards and guidelines on o