Dickinson

Disability Documentation Form for ACADEMIC ACCOMMODATION REQUESTS

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROFESSIONAL

Dickinson College is deeply committed to the full participation of students with disabilities in all aspects of College life. This form, along with medical documentation, will help Access and Disability Services determine this student's eligibility for academic accommodations. It is to be completed by a licensed physician or other qualified health care provider with experience and expertise regarding the functional limitations of the student's disability, current symptomology, and potential impact on the student's participation in the academic environment. The health care professional completing this form must be an impartial individual who is not a family member of the student.

Thank you in advance for providing as much detail possible in your responses

Student's Name: _____ **Date of Birth:** _____

Care Provider Information

Provider Name: _____

Credentials: _____

Email: _____

Telephone: _____

Practice Name and Address
(Stamps welcome)

The student named above has requested disability-based academic accommodations at Dickinson College. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities." Examples of major life activities are listed in Item 4. A temporary impairment may include an injury, severe illness, recovery from surgery, or a condition caused by a traumatic event.

1. **Under the ADA, this individual has a…** *(please select one)* ☐ **Disability** **or** ☐ **Temporary Impairment**
2. **Please cite the student's diagnosis:**

Dx #1: _____ Diagnostic code: _____

Dx #2 _____ Diagnostic code: _____

Dx #3 _____ Diagnostic Code: _____

From the:

☐ **DSM-IV-TR** ☐ **DSM-V** ☐ **ICD-9** ☐ **ICD-10**

3. **How was this diagnosis made? (i.e. What focus of assessment did you rely upon?)**

4. **Please check the major life activity(ies) that are substantially limited by the disability/impairment:**

☐ walking	☐ hearing	☐ seeing	☐ manual tasks
☐ reading	☐ working	☐ learning	☐ breathing
☐ lifting	☐ eating	☐ sleeping	☐ concentration
☐ speaking	☐ thinking	☐ standing	☐ communicating
☐ bending	☐ self-care	☐ the operation of major bodily functions	
☐ other:			

5. **Date of diagnosis:** **Made by you?** ☐ **Yes** ☐ **No, Dx made by:**
6. **Number of consultations with you in the past 3 years:** **Date of your most recent evaluation:**
7. **Length of time under your care:**
8. **Currently under your care?** ☐ **Yes** ☐ **No, care ended on:**
9. **Medical/therapeutic equipment needed:**
10. **Describe any relevant side effects of prescription medication(s):**

11. **Please describe in detail the symptoms currently experienced by the student**.

12. **Please describe in detail how the disability interferes with one or more major life activities as would be encountered in the academic environment**. *(Attachments welcome if additional space is needed.)*

13. Please indicate the approximate frequency of symptoms experienced:

☐ periodic - # of annual occurrences: ☐ ☐ x per month ☐ most days

☐ seasonal - # of annual occurrences: ☐ ☐ x per week ☐ daily

How long do symptoms typically persist?

Other/Comments?

14. What accommodations(s) are you recommending for this student to ensure equitable access to the curriculum?

Note: A connection must be established between the requested accommodations and the functional limitations on the student in the academic environment. If not correlated with the above noted symptomology, please provide rationale for your recommended accommodation(s).

☐ Extended time on tests (time and a half is the standard)

☐ Testing in a distraction-reduced environment

☐ Support with class notes

☐ Other: _____

☐ Other: _____

☐ Other: _____

15. Accommodations for this condition are recommended

☐ for several months… How many? ☐ ☐ for the duration of the student's time in college

☐ for the next year ☐ duration is unknown at this time

Other/Comments:

16. ☐ I have attached supporting documentation for this diagnosis. (www.dickinson.edu/ADS-Guidelines)

I confirm the validity of all information herein and attest that I am not related to this student.

Please print and manually sign here

Care Provider's Signature **Date**

THIS COMPLETED FORM IS NOT TO BE GIVEN TO THE STUDENT. IT SHOULD BE SENT DIRECTLY TO DICKINSON

Thank you for printing, signing and returning this form to Access and Disability Services as soon as possible via

Email:	**Fax :**	**US Mail:**
access@dickinson.edu	(717) 254-8139	PO Box 1773, Carlisle, PA 17013

Questions? Call: 717-245-1734