

Disability Information Form

For use by qualified healthcare, mental health, educational, or diagnostic professionals

Purpose and Instructions

Disability Resources and Services (DRS) provides academic services and accommodations for students with diagnosed disabilities. Documentation must demonstrate a physical or mental impairment that substantially limits one or more major life activities under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA), as amended.

Please complete all applicable sections as thoroughly as possible. Incomplete, unclear, or illegible information may delay the eligibility review process because DRS may need to request clarification. Providers may also submit a signed letter on letterhead, but the letter should include the same information requested in this form.

The information provided will be maintained securely and confidentially in the student's DRS file.

Student Information - To be completed by student

First Name:	Last Name:
Date of Birth:	MEID:
Alternate Email:	Phone Number:
Address:	City, State and Zip

☐ Current student ☐ Transfer student ☐ Prospective student

Remaining information must be completed by the provider

1. Provider Relationship to Student

☐ Treating provider ☐ Evaluator/diagnostician ☐ Specialist consultant ☐ Other

Date of first contact/evaluation: _____ Date of most recent contact/evaluation: _____

2. Diagnostic Information

Primary diagnosis/condition, including DSM/ICD code if applicable:		Date of diagnosis:
Secondary diagnosis/condition, including DSM/ICD code if applicable:		Date of diagnosis:
Is the diagnosis current?	Expected duration/course:	
Date of last evaluation:	Was documentation reviewed or attached?	

3. Basis for Diagnosis/Assessment Methods

Please identify the assessment methods, clinical procedures, records, or tools used to determine the diagnosis and current functional impact. Check all that apply and briefly describe relevant findings.

☐ Clinical interview	☐ Behavioral observation	☐ Mobility/physical assessment
☐ Treatment history / response to treatment	☐ Standardized rating scales or symptom inventories	☐ Lab results, imaging, or specialist evaluation
☐ DSM-5 / ICD diagnostic criteria	☐ Neuropsychological evaluation	☐ Medical examination
☐ Psychoeducational evaluation	☐ Academic achievement testing	☐ Review of medical records
☐ Cognitive testing	☐ Vision evaluation	☐ Audiological evaluation
☐ Other (please specify):		

Briefly describe how the assessment results support the diagnosis and the student's current functional limitations in an academic setting:

4. Current Severity and Course of Condition

- ☐ Mild ☐ Moderate ☐ Severe ☐ Varies / episodic ☐ Temporary ☐ Chronic / ongoing ☐ Permanent
☐ Currently stable with treatment ☐ Symptoms may fluctuate despite treatment

If temporary, expected duration: _____

If the condition is episodic, variable, or flare-based, please describe typical frequency, duration, triggers, recovery time, and academic impact:

5. Treatment, Supports, and Related Impacts

Please identify any treatment, medication, therapy, assistive device, or management strategy related to the student's functional limitations. Include any side effects, schedules, symptom-management needs, or recovery periods that may affect academic participation.

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6. Major Life Activities and Academic Functions Assessment

For each area, indicate the current degree of functional limitation.

- **None/Negligible:** Condition is present but has minimal or no impact on access, participation, or functioning.
- **Moderate Limitation:** The student can generally perform the life activity, but with meaningful difficulty, increased effort, extra time, or support.
- **Severe Limitation:** The student's ability to perform the life activity is substantially restricted, inconsistent, or dependent on significant support or accommodation.
- **Not Sure:** Use only when the available information does not allow you to assess the area.

Life Activity / Academic Function	None or Negligible	Moderate	Substantial	Not Sure
Attending classes and labs	☐	☐	☐	☐
Campus Navigation	☐	☐	☐	☐
Class participation	☐	☐	☐	☐
Communicating	☐	☐	☐	☐
Emotional Regulation	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Managing distractions	☐	☐	☐	☐
Meeting Deadlines	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Mobility/Physical access	☐	☐	☐	☐
Oral Presentations	☐	☐	☐	☐
Organization/Executive Functioning	☐	☐	☐	☐
Processing Speed	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Vision	☐	☐	☐	☐
Self-Advocating/Seeking support	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Stamina/Fatigue	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Taking Exams	☐	☐	☐	☐
Taking Notes	☐	☐	☐	☐
Use of technology or course materials	☐	☐	☐	☐
Working in groups/Collaborating	☐	☐	☐	☐

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7. Functional Limitation in the College Environment

For each area marked moderate or substantial, please describe how the disability currently limits the student in a postsecondary academic environment. Please include the nature, severity, frequency, and duration of the limitation when known.

Functional limitations may impact classroom participation, testing, reading, writing, note-taking, assignment completion, attendance, communication, concentration, memory, processing speed, stamina, mobility, clinical/lab participation, online learning, or access to course materials.

8. Accommodation Recommendations and Functional Rationale

Please state any recommended academic accommodations and explain the disability-related functional limitation each recommendation is intended to address. Recommendations will be considered by DRS as part of the interactive process; DRS is responsible for determining reasonable accommodations in the college setting.

Recommended Accommodation	Functional Limitation Addressed	Provider Rationale

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9. Additional Comments or Context

Please include any additional information that may assist DRS in understanding the student's disability-related access needs. This may include environmental barriers, previous accommodations, assistive technology, safety considerations, or limitations that may differ by course format, lab, clinical, fieldwork, or online learning environment.

10. Provider Information and Certification

By signing below, I certify that I am a qualified professional with training, licensure, certification, or clinical experience relevant to the diagnosis or condition identified above. I further certify that the information provided is accurate to the best of my knowledge and is based on my professional assessment, treatment relationship, or review of relevant records.

Provider Name:	Title/Credentials:
License/Certificate Number:	Specialty/Area of Practice:
Organization/Practice Name:	Preferred contact method for follow-up clarification:
Phone Number:	Email:
Address:	City, State & Zip:
Provider Signature:	Date:

Optional Attachments

- ☐ Psychological/psychoeducational evaluation ☐ Medical record summary ☐ Audiogram/vision report
- ☐ Other (please list) _____