PHYSICAL/MEDICAL DISABILITY DOCUMENTATION REQUEST FORM
CENTER FOR EQUAL ACCESS

Student’s Name: __________________________________________ Date of Birth: ___ / ___ / ______
Address: __________________________________________ City______________________ State ________Zip ________

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodation(s) from the Center for Equal Access. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, CSS Policy requires that a **Qualified Professional** provide current and comprehensive documentation. A qualified professional includes a medical doctor or other qualified healthcare professional.

**IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL’S STATEMENT MUST BE WITHIN 3 YEARS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM THE CENTER FOR EQUAL ACCESS.**

The documentation provided must include information that diagnoses a physical or systemic (medical) disability, describes the functional limitations in an educational setting, indicates the severity and longevity of the physical or systemic (medical) disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication along with any current side-effects that may impact academic performance. If it is a visual disability, the documentation must include the student’s visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged text is recommended as an accommodation.

To facilitate the gathering of such critical information, please respond to the following and return to the Center for Equal Access.

1. DSM IV-TR OR ICD-9-CM Diagnosis and Codes
2. Date of Diagnosis: ___ / ___ / ______
3. Last Date of Contact with Student______ / _____ /______

4. In addition to the DSM- IV or ICD-9-CM criteria, what assessments or methods did you use to arrive at your diagnosis (please check all that apply)?
   ___ Structured or unstructured interviews with student
   ___ Interviews with other persons
   ___ Behavioral observations
   ___ Developmental history
   ___ Educational history
   Comments:

5. How long do you anticipate the student’s academic achievement will be impacted by this disability?
   ___ up to six months ___ up to one year ___ up to 5 years ___ long term

6. Provide a brief summary of the student’s educational, medical, and family history that relates to the physical or systemic (medical) disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction):

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

7. Please indicate which **major life functions** below are affected because of the physical diagnosis. Please indicate the **level of limitation**:

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# PHYSICAL/MEDICAL DISABILITY DOCUMENTATION REQUEST FORM
## CENTER FOR EQUAL ACCESS

<table>
<thead>
<tr>
<th>LIFE ACTIVITY</th>
<th>NO IMPACT</th>
<th>MODERATE IMPACT</th>
<th>SEVERE IMPACT</th>
<th>UNABLE TO DETERMINE</th>
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<tbody>
<tr>
<td>Concentrating</td>
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<td>Memory</td>
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<td>Sleeping</td>
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<td>Self Care</td>
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<td>Mobility</td>
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<td>Writing or Typing</td>
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<td>Reading</td>
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<td>Managing internal distractions</td>
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<tr>
<td>Managing external distractions</td>
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<td>Timely submission of assignments or exams</td>
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<td>Attending class regularly and on time</td>
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<td>Stress management</td>
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<td>Other (please indicate):</td>
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Comments on any of the areas:

5. List current medication along with any current side effects that may impact academic performance:

   Medication 1: ________________________ Side Effect: ________________________________
   Medication 2: ________________________ Side Effect: ________________________________
   Medication 3: ________________________ Side Effect: ________________________________

6. Please indicate the RECOMMENDATIONS you regard as necessary and appropriate auxiliary aids or services, academic adjustments, or other accommodations to equalize the student’s educational opportunities at CSS as justified based on the functional limitations indicated above.

   Please check all that apply:
   ___ extended time on exams or in-class assignments
   ___ distraction-reduced environment for testing
   ___ alternative test format
   ___ no scantron
   ___ books on tape
   ___ reader
   ___ other
   ___ consideration for absences
   ___ note taker
   ___ enlarged text (font size ___)
   ___ scribe

Qualified Professional’s Signature: ____________________________________________
License Number: ____________________________ Date: ____________________________

Printed Name & Title: __________________________________________________________
Daytime Telephone Number: _____________________________________________________
Address: _____________________________________________________________________

Please return this form directly to:

**Center for Equal Access**
The College of St. Scholastica 1200 Kenwood Avenue Duluth, Minnesota 55811
Ph: (218) 723-6747 Confidential Fax: (218) 723-6482
access@css.edu (pdf only)

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