Medical Documentation of Disability Form for Academic Accommodations

Student Accessibility and Accommodation (SAA)

1500 N. Warner St. #1096, Tacoma, WA 98416-1096, T: 253.879.3395 or 3399, F: 253.879.3786

Student’s Name: ___________________________ Student DOB: ___________________________
ID#________________________ Telephone________________________ Date: __________________

SAA complies with federal and state disability laws that prohibit discrimination and require that universities ensure equal access for qualified persons with disabilities to educational programs, services and activities. Please complete the form below to assist SAA in determining appropriate and reasonable disability accommodations. Additional documentation may be required.

**To be completed by the student’s treating professional**, NOT by a family member. All items are required. Please print legibly.

Complete Diagnosis: ________________________________________________________________

Date of Diagnosis: __________________________

Date of last visit for this condition: __________________________

Procedures/assessments used to diagnose this student’s condition (ATTACH COPIES of assessment results used in making/confirming diagnosis):

___________________________________________________________________________

Severity of the condition: Mild Moderate Severe

Student is compliant with medical treatment for this condition: Rarely Sometimes Often Unknown

Does this student take prescription medication for this condition? Yes ___ No ___ If yes, which medications? Please note any side effects:

___________________________________________________________________________

Has this student been treated in an emergency room for this condition within the last year? Yes ___ No ___

Has this student received in-patient treatment for this condition within the last year? Yes ___ No ___

Describe how this condition substantially limits a major life activity. (Activities that the average person can perform with little or no difficulty)

___________________________________________________________________________

How often does this student experience the above limitation(s)? Rarely Occasionally Frequently

How will the above limitation(s) interfere with this student’s ability to participate in student life (e.g., academics, recreation, etc.)?

___________________________________________________________________________

Describe any substantial equipment prescribed for this student’s home or school environment:

___________________________________________________________________________

Describe your follow-up plan for your patient:

___________________________________________________________________________

Recommended accommodation (must be clearly linked to functional limitations):

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Affix business card or apply business stamp within this box

Treating Professional
Name: __________________________ Address: __________________________
License/Cert. #: __________ State: _________ Specialty: __________________________
Phone: ___________________ Fax: ___________________