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. The Director of SAA may contact the professional who completed this form for clarifications or additional information.

**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:
________________________________________________________________________________________

________________________________________________________________________________________

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):
________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Treating Professional
Signature: ________________________________________________________________________________

Affix business card or apply business stamp within this box

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Email: saa@pugetsound.edu

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Revised 04/25/2017