Medical Documentation of Disability Form
STUDENT ACCESSIBILITY AND ACCOMMODATION
1500 N. Warner St. #1096, Tacoma, WA 98416-1096, T: 253.879.3399 or 3396, F: 253.879.3786
Email: saa@pugetsound.edu

Student’s Name:___________________________ Student ID# __________________________
Date ________ Town and State ____________ Telephone ____________________________

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.

By signing here you are permitting your mental health professional and Student Accessibility
and Accommodation to discuss the information provided on this form and any other
information needed to determine eligibility for disability accommodations. Please complete
any release of information forms required by your treating professional.

Student_________________________ Date ____________________

Treat Medical Professional, please complete the form below to assist SAA in determining
appropriate and reasonable disability accommodations. SAA may contact the professional
who completed this form for clarifications or additional information.

Date of your first visit with the student? ________ How many times have you seen the student? __

What is the diagnosis? ________________________________________________

Who made the diagnosis? _______________________________________________
Date of diagnosis _________________________

What are the clinical significant symptoms and signs?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

What are the major life activity impairments?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Procedures/assessments used to determine diagnosis and severity of symptoms
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
How will the above limitation(s) interfere with this student’s ability to participate in student life (e.g., academics, residence halls, recreation, etc.)?

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Does this student take prescription medication for this condition? Yes  No

If yes, which medications? Please note any relevant side effects:

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Has this student been treated in an emergency room for this condition within the last year?

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

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

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Professional’s Signature:  
Affix business card or apply business stamp below

Date: ________________________________

Please Print Name: ________________________________

Address: ________________________________

License / Cert. #: ________________________________  State: ______

Phone: ________________________________

Revised 1/24/20