Documentation of Disability Form

STUDENT ACCESSIBILITY AND ACCOMMODATION
1500 N. Warner St. #1096, Tacoma, WA 98416-1096
T: 253.879.3399 F:253.879.3786 **Email: saa@pugetsound.edu**

Student's Name:_____ Student ID#:_____

D.O.B:_____ Town and State:_____

Telephone:_____ Email:_____

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 the professional who completed this form 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 Signature:_____ Date:_____

Dear diagnosing / treating professional,

Please complete the form below to assist SAA in determining appropriate and reasonable disability accommodations. SAA may contact you 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 clinically significant symptoms and signs?

_____

_____

List any major life activity impairments:

_____

_____

_____

_____

List all 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 the 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 ▢

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 06/23/2026