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 _____________________

Treating 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?

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____

____

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: ________________________________