Physical/Medical Disability – Documentation Guidelines

Documentation submitted to the Center for Disability Services must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activity (e.g. walking, seeing, speaking, hearing, breathing, learning, etc.). A diagnosis of a condition does not automatically qualify a student for accommodations under the Americans with Disabilities Act. **The documentation for a physical or medical condition must demonstrate that the condition rises to the level of a disability.**

The documentation should include the following specific components:

- **Format** – typed/printed on official letterhead, dated, and signed from a licensed and qualified professional (e.g. physicians, surgeons, optometrists, audiologists, physical therapists, occupational therapists, neuropsychologists, and other relevantly trained healthcare professionals qualified to make such diagnoses).

- **Diagnosis** – the ICD or DSM-IV coded diagnosis.

- **History and Prognosis** – a summary of the history and prognosis of the condition.

- **Treatment** – relevant information regarding the current treatment of the condition.

- **Current Impact** – a summary of current symptoms, severity, and impact of the condition.

- **Limitations** – a statement regarding the functional limitations of the condition on learning and major life activities.

- **Auxiliary Aids** – a statement regarding the use of auxiliary devices (if applicable).

- **Medications** – a summary of the medications prescribed with their current effects. (A positive response to medication does not necessarily confirm a diagnosis or support/negate the need for accommodations.)

- **Assessment Procedures** – a summary of the assessment procedures used to make the diagnosis and the results of the evaluation, including standardized and percentile scores (if applicable).

- **Accommodations** – a summary of recommended and suggested accommodations. (Requested accommodations must be tied to the functional limitations of the individual relevant to the academic setting. A history of accommodations without demonstrating current need does not necessarily warrant accommodations. If there is no history of
accommodations the documentation must include a detailed explanation of why accommodations were not needed in the past and why they are now requested.)

Please also note the following statements regarding documentation:

• **Documentation must be recent.** Although some individuals have long-standing or permanent conditions, because of the changing manifestations of many physical and medical disabilities, it is essential that a student provide recent and appropriate documentation from a qualified evaluator. If the diagnostic report is more than **one year** old, the student must submit a letter from a qualified professional that provides an update of the diagnosis, a description of the student’s current level of functioning during the preceding year, and a rationale for the requested accommodations.

• Psycho-Educational or Neuropsychological Assessments are often necessary to support the need for accommodations when physical or medical conditions interfere with cognitive performance.

• Documentation may be provided from more than one source when a clinical team approach consisting of a variety of educational, medical, and counseling professionals has been used.

• **Diagnoses of physical or medical disabilities documented by family members will not be accepted** due to professional and ethical considerations even when the family members are otherwise qualified by training and licensure/certification.

• If the disability co-exists with another condition, please refer to the appropriate documentation guidelines for additional information.

• The student’s advisor and the Center for Disability Services case management team will determine if the student qualifies for accommodations and what accommodations should be implemented.