Disability Assessment Form

Return to: Disability Services, Athens State University
300 North Beaty Street, Athens, AL 35611
Fax: (256) 233-8143
E-mail: disability.services@athens.edu

To Whom It May Concern:

A patient/client of yours has requested disability-related services from Disability Services at Athens State University. Legal protection and eligibility for such services is based on an individual providing sufficient information to conclude that he or she has an impairment that **substantially limits** one or more major life activities. As this student's treating specialist, you are asked to provide the following information to allow the university to consider this student's service request(s).

Please complete the following:

1. Patient/Client Name:

2. The Condition of Patient/Client:

A. What is the diagnosis/impairment?

B. When was the diagnosis originally made?

C. Is the patient/student currently under your care?

D. When did you last see the patient/student?

E. Is the impairment temporary (< 3months) or persistent?

F. Please identify any factors that may affect the severity of the impairment (e.g., to what degree might the impairment be *minimized* by medications, hearing aids, etc.?) Alternatively, could there be an adverse affect (e.g., medication side effects)?

3. Please complete the following: FUNCTIONAL IMPACT ASSESSMENT

LIMITATION IS: 1 =Unable to Determine 2 = Mild 3 = Substantial

1	2	3	Major Life Activity		1	2	3	Major Life Activity
			Caring for oneself					**Learning**
			Talking					• **Reading**
			Hearing					• **Writing**
			Breathing					• **Spelling**
			Seeing					• **Calculating**
			Walking/Standing					• **Concentrating**
			Lifting/Carrying					• **Memorizing**
			Sitting					• **Listening**
			Performing Manual Tasks					**Other:**
			Eating					
			Working					
			Interacting with Others					
			Sleeping					

4. What method(s) were utilized to assess functional limitation? Please list or attach under separate cover. If possible, please attach diagnostic report.

5. Please list your recommendations for accommodations within the academic environment. Please provide a rationale for any recommendation made utilizing data from objective measures, the educational record, or other data sources. Please list or attach under separate cover.

6. Certifier Information:

Clinician Name_____

Medical Specialty_____

License_____

Address_____

Phone_____

Email_____

Date_____

If you have further questions, please feel free to contact Athens State University Disability Services at 256.233.8143. Thank you.

SOURCE: UNIVERSITY OF WISCONSIN