

Documentation of a Disability

In order for the Office of Disability Resources (ODR) to determine appropriate academic accommodations, we ask the student to provide information on the current functional impact of their diagnosis by a certified, or licensed healthcare professional, in addition to their personal self-report. Individuals chose to self-disclose and provide current documentation to ODR in order to receive academic accommodations at the University of Mary Washington. When providing information necessary to evaluate eligibility for academic accommodations, please adhere to the following:

1. **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These professionals are generally trained, certified, or licensed psychologists or members of a medical specialty, with no relation to the individual. It is recommended that the licensed provider completing this form has in-depth knowledge of your diagnosis and current needs.
2. **Encourage your healthcare professional to answer the questions thoroughly with information that pertains to your individual impact.** Illegible handwriting may delay the eligibility of accommodations and/or the review process.
3. **Please note that some diagnoses require information in addition to, or at times instead of, this form.** Additional reports and evaluations can be attached to this form in order to provide us with additional required information (for example: psychological, psycho-educational testing, neuropsychological testing, medical reports, etc). A comprehensive diagnostic report can be submitted for documentation instead of this form. Please do not provide case notes or rating scales without a narrative that explains the results.
4. **Once the form is completed by your healthcare professional and returned to you, please upload the form and/or additional paperwork to your registration form (if you are new to ODR) or directly to your student accommodate portal (if you have already completed the registration form).** Documentation can not be received by ODR in print form or via email, we require documentation to be uploaded to the students accommodate portal as stated in our [Process of Registering with the Office of Disability Resources](#).

If you have questions regarding this form or the registration process, please call our office at 540-654-1266 or email odr@umw.edu.

Student Information

(Please Print Legibly or Type)

****Please be advised this form will need to be saved before entering information to ensure it will not be blank.**

Student Name: _____

Banner ID Number: _____

Date of Birth: _____

To be completed by the Certifying Professional:

Date Last contact with student: _____

Date of Diagnosis: _____

1. Please state the complete Diagnosis/Diagnoses:

2. Please describe your history in working with this student with this diagnosis (i.e. duration of time):

3. Please describe the assessment or evaluative measures used to determine the diagnosis/diagnoses:

4. Please provide information on the current symptoms supporting diagnosis (Symptoms within the last 6 months):

5. Please explain the functional limitations and impact of the condition on daily life, to include academic performance:

6. How would you categorize this condition in terms of severity? Please check only one and explain below:

Minimal Moderate Severe Residual/Remission Other:

7. The Condition is: Stable Prone to Episodes Other: _____

8. What are the current medications and/or other treatments being received by the student? Please include side effects experienced by the student that may impact their learning:

9. Please provide any additional relevant information you feel we need to be aware of in order to determine appropriate accommodations in higher education which allows us to provide the student with equal access.

10. Please include suggested accommodations for this student. Each recommended accommodation should include a detailed explanation of its relevance to the student's disability (may include impact of medication).

Certifying Professional Information:

Healthcare Professional Name (Print): _____

Credentials: _____

License or Certification #: _____

Address: _____

Telephone: _____ Fax: _____

Email Address: _____

Signature: _____ Date: _____