Denison University Academic Resource Center

Disability Due to a Medical Condition

STUDENT'S NAME: _____ DOB: _____

Accommodation Requested *(check all that apply)*
_____ Academic _____ Housing

Healthcare Provider's Signature: _____ Date: _____

Agency/Institution: _____

Address: _____ Phone: _____

INTRODUCTION

Students who are seeking disability services through Denison's Academic Resource Center on the basis of a diagnosis of a medical impairment are required to submit documentation to verify eligibility under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 as amended.

Under the Americans with Disabilities Act Amendments Act (ADA AA) revised in 2008, the term "disability" includes (a) a physical impairment that substantially limits one or more of the major life activities of an individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment. It is important to understand that a diagnosis of a medical condition in and of itself does not substantiate a disability. In others words, information sufficient to render a medical diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. Current and comprehensive documentation must be provided in order for a student to be eligible for support services and considered protected under the law.

The International Classification of Diseases is frequently used as guidance for identifying medical conditions. However, not all conditions listed in the ICD-9/10 are disabilities or even impairments for purposes of the ADA. Diagnosis by a licensed medical professional (a physician, a physician assistant or an advanced practice nurse practitioner) with expertise in the area of concern is required. The healthcare provider must be an impartial evaluator who is not a family member nor in a dual relationship with the student.

ALL QUESTIONS BELOW MUST BE COMPLETED BY A QUALIFIED HEALTHCARE PROVIDER

Note to Providers: This assessment should be current (six months to one year), include a clearly stated diagnosis, and must provide information about the significant impact to a major life function, including those expected for a post-secondary experience.

Healthcare Provider's Name: _____

Credentials and State License #: _____

ICD-9 or ICD-10 primary diagnoses: _____

1. How long have you been providing care to this student for this particular medical condition?

2. Date of most recent office visit: _____ and

   Dates of last three visits related to this medical condition 1)_____ 2)_____ 3)_____

3. Date of onset of current episode: _____

Student Name:_____ DOB:_____

4. Current medications:

_____

5. How has prescribed medication affected the student's functioning?

_____

6. Current treatments, assistive devices and/or technologies:

_____

7. What is the severity of the medical condition? _____ Mild _____ Moderate _____ Severe
Please explain:

8. What is the expected duration of the medical condition or disability?
_____ Long term: 3 – 12 months or longer
_____ Short term: 60 – 90 days
_____ Temporary: less than 60 days
Please explain:

9. Is the medical condition: _____ Acute _____ Chronic _____ Episodic
Please explain:

10. Specific duration, stability, or progression of the condition or disability:

_____
_____

11. Describe the symptoms your patient presently displays:

12. Is there evidence that the symptoms <u>currently</u> meet ICD-9 or ICD-10 criteria? _____ Yes _____No
If yes, please describe symptoms and functional impairment.

13. Does the diagnosed condition rise to the level of a disability (according to the definition on page 1)? ____Yes ____No
If yes, please describe symptoms and functional impairment.

Student Name:_____ DOB:_____

14. Please provide a brief summary of clinical and/or observational data (e.g. recent lab/bloodwork results, test results, ongoing therapy):

15. What is the current impact of (or limitations imposed by) the condition?

16. Please check the extent to which major life activities are affected by the disabling condition.:

Life Activity	**No Impact**	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Don't Know**	**Not Applicable**
ADLs (e.g. hygiene/bathing, eating, etc.)						
Attending class, lectures, labs, etc.						
Communicating – verbal or written						
Concentrating						
Learning						
Living in an unstructured environment such as a residence hall (dorm)						
Living with a roommate						
Sleeping or Waking						
Socializing						
Studying independently, in a group, etc.						
Other (please specify)						

Student Name:_____ DOB:_____

17. Provide recommendations for **academic** accommodations (e.g. extra time to complete exams). Include a clear rationale between key components of the diagnosed condition and the accommodation requested and any past accommodations and their effectiveness.

18. Provide recommendations for **campus housing** accommodations (e.g. a single room, an emotional support animal*). Include a clear rationale between key components (symptoms, functional limitations) of the diagnosed condition and the accommodation requested and any past accommodations and their effectiveness.

19. What parts of the student's academic, social, or campus life experience will the student be unable to access without your recommended accommodations?

Medical Provider Signature:_____ Date:_____

Please return completed form to

Academic Resource Center

Denison University, 100 West College Street, 020 Higley Hall, Granville, OH 43023

arc@denison.edu *Fax: 740-868-1168*

As part of the review to evaluate the request for a reasonable accommodation, this information will be shared with the Hoaglin Wellness Center at Denison University