
DISABILITY DOCUMENTATION FORM

For students with mobility impairments and other functional impairments due to medical conditions

Date: _____

Name of Student: _____

Dear Medical Professional:

The student whose name appears above has applied for services/accommodations through the office of Student Support Services at Shorter University. In order to determine his/her eligibility for services, we will need your assessment and diagnosis of this student. A disability is defined as a physical or mental impairment that limits one or more major life activities such as those delineated below. You can fax or mail this form to us at the address listed above. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

1. What is diagnosis/impairment?

2. Date of above diagnosis: _____

3. Date student was last seen: _____

4. Is the patient/student currently under your care: _____

5. Major Life Activities Assessment: Please check which of the major life activities listed below are affected because of the impairment. Please indicate level of limitation.

Life Activity	Negligible	Moderate Impact	Substantial Impact	Don't Know
Talking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Writing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performing Manuel Tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Memorizing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interacting with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for oneself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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6. What are the specific functional limitations resulting from the impairment's impact on the major life activities identified above (i.e., unable to keyboard more than 10 minutes out of 60 minutes)?
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7. Please attach any other supporting information (e.g., neurological or psycho-educational reports, etc.)

8. Medications, effects, and possible side-effects:

9. If student is currently undergoing treatment, please describe the treatment and how treatment may affect the student in a post-secondary setting.

10. Are functional limitations permanent? If not, anticipated date of resolution?

11. CERTIFYING PROFESSIONAL *

Signature of Medical Professional

Date

Professionals Name (printed) and Title

License No.

Address

Telephone No.

City, State, Zip

Fax
