Southern Arkansas University
Disability Documentation Form
To be completed By the Student’s Health Care Provider

Southern Arkansas University is deeply committed to the full participation of students with disabilities in all aspects of college life. In accordance with section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), and the Fair Housing Act (FHA), Southern Arkansas University College has established procedures to ensure that students with documented disabilities are reasonably accommodated in SAU program activities.

Student Name: ___________________________ Student ID: ___________________________
Address: ___________________________ City: ___________ State: ___________
Cell Phone: ___________________________ Email: ___________________________

I authorize ___________________________ (physician/therapist/mental health provider) to release information pertinent to my physical/mental condition to Disability Support Services at Southern Arkansas University, Magnolia, AR. By my signature, I also give my consent for SAU’s Office of Disability Support Services (DSS) to contact my healthcare provider for additional information as needed, and further give my consent to my healthcare provider to discuss my situation with the Office of Disability Support Services (DSS) and/or the SAU’s Health and Counseling Centers.

Student Signature: ___________________________ Date: ___________________________

_Please type or print_

The student named above has requested an accommodation from Southern Arkansas University because of a disability. A disability is defined under the Americans with Disabilities Act as a “physical or mental impairment that substantially limits one or more major life activities.” Examples of major life activities are: seeing, hearing, speaking, breathing, eating, sleeping, walking, standing, lifting, bending, learning, reading, communication, working, performing manual tasks, caring for oneself, thinking, concentrating, and the operation of major bodily functions.

_Note:_ Diagnosis by a licensed medical professional including: but not limited to Medical Doctors, Physician Assistants, Nurse Practitioners, Psychiatrist, Mental Health Professionals, or other medical professional with experience and expertise in the area for which accommodations are being requested.

PRIMARY CARE PROVIDER SECTION: (Please type or print)

1. Based on this definition, does this individual have a disability? _____Yes _____No

2. If yes, please cite the medical diagnosis of the physical disability, systemic illness or summary of presenting symptoms.

Disability: ___________________________ Date Diagnosed: ___________________________

The code for this is from the: _________DSM-IV-TR _________DSM-V _________ICD-9 ICD-10

Disability: ___________________________ Date Diagnosed: ___________________________

The code for this is from the: _________DSM-IV-TR _________DSM-V _________ICD-9 ICD-10
3. Number of consultations in the past three years: ______ Date of most recent evaluation: ______

4. Length of time under your care? ________ Currently under your care? ______ Yes ______ No

If no longer under your care, when did care end? ________________________________________________

5. Medical/therapeutic equipment needed/prescribed: ______________________________________________

6. Prescribed medication(s) (indicate dosage): (use back if necessary)

   Medication _____________________________ Dosage _____________________________

   Medication _____________________________ Dosage _____________________________

   Medication _____________________________ Dosage _____________________________

   Medication _____________________________ Dosage _____________________________

   Medication _____________________________ Dosage _____________________________

7. Does medication mitigate the student’s symptoms? (Circle all applicable responses.)

   COMPLETELY PARTIALLY NOT MITIGATED

8. Are there any side effects from medication that impacts academic functioning? ______ Yes ______ No

   If so, please describe: _______________________________________________________________

9. Is the student compliant in taking prescribed medication? ______ Yes ______ No

10. Please circle (and indicate, where relevant) the appropriate frequency of symptoms experienced:

    Periodic / Seasonal every month(s) x a month x a week most days daily

    ( annual reported occurrences)

11. Please check which of the following major life activities this condition(s) substantially limits:

    ___walking ___hearing ___seeing ___manual tasks ___speaking

    ___reading ___working ___learning ___breathing ___thinking

    ___lifting ___eating ___sleeping ___concentrating ___standing

    ___communicating ___bending ___self-care ___the operation of major bodily functions

    ___Other(s): ________________________________________________________________

12. How substantial are the current limitations compared to the average person in the general population?
    (circle one)

    MILD MODERATE SEVERE PROFOUND
13. List the ways the student’s learning is impacted, specific to the post-secondary environment (e.g. difficulty with concentration, slow processing speed, stress tolerance, difficulty with reading comprehension or writing, visual or auditory problems, etc.)

14. Please initial by each accommodation you are recommending. Please note that all accommodations will be based on a review.

Testing
- [ ] extended time (hours, not days)
- [ ] time and half or
- [ ] double time
- [ ] other
- [ ] non-distracting environment
- [ ] oral exam
- [ ] verbatim text reader
- [ ] scribe
- [ ] alternate day/time
- [ ] no Scranton (bubble sheets)
- [ ] other ____________________________

Physical Environment
- [ ] preferential seating
- [ ] alternative chair/table
- [ ] classroom breaks
- [ ] liquid or food in class

Assistive Technology
- [ ] computer/word/processing for in class writing
- [ ] spellchecker
- [ ] tape/digital recorder
- [ ] Braille texts
- [ ] handouts in alternate format
- [ ] audio books or electronic format

Other
- [ ] notetaking
- [ ] interpreter (sign language)
- [ ] other ____________________________

Requests (At the instructor’s discretion IF course integrity is not impacted)
- [ ] extended time for assignment completion
  (1-2 days extra, including in-class writing assignments)
- [ ] consideration for missed classes due to disability

15. Additional recommended accommodations?

16. Please attach supporting documents for this diagnosis. (see next page for details)

Health Care Provider’s Contact Information/Certifying Professional (Stamp or Write)

Clinic/Office: ____________________________

Name: ____________________________ Title: ____________________________

State of License: ____________________________ License Number: ____________________________

Address: ____________________________ City: ____________________________ State: ____________________________

Email: ____________________________ Phone Number: ____________________________

I have attached the supporting documentation for this diagnosis.

Signature: ____________________________ Date: ____________________________
Supporting Documents

Different medical conditions require different assessment procedures. Documentation which supports the diagnosis and legitimizes a student’s request for appropriate accommodations may include:

- Copies of office visit summaries related to the accommodation request
- Lab test results
- A summary of the impact of medications taken and the rationale for current medication prescribed
- A summary of assessment procedures, along with specific evaluation results
- A summary of present and/or fluctuating symptoms that meets the criteria for diagnosis
- Relevant developmental and historical data, if appropriate

Any summaries provided should be typed on official letterhead with clear contact information.

Documentation for eligibility must reflect the current functional impact the disability has on the student’s learning or other major life activity and the degree to which it impacts the individual in the context (dining, residential, etc.) for which accommodation are requested.

A connection must be established between the requested accommodation and the functional limitations on the student in the college environment (learning, residential, etc.).

Care providers should send disability documentation directly to the Office of Disability Support Services in one of the following ways:

Sandra Martin  
Southern Arkansas University  
University Housing  
100 E University  
Magnolia, AR 71753  
Phone: 870 235 4047  
Fax: (870) 235 5264