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:**_____

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 (annual reported occurrences)	every month(s)	x a month	x a week	most days	daily

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