EASTERN CONNECTICUT STATE UNIVERSITY
83 WINDHAM STREET • WILLIMANTIC, CONNECTICUT 06226 • 860-465-5000

# The Office of AccessAbility Services

## Documentation of Disability Form – Temporary Injuries

**Dear Provider:**

The Office of AccessAbility Services (OAS) at Eastern Connecticut State University complies with federal and state disability laws that prohibit discrimination and require that universities ensure equal access for qualified persons with disabilities to educational programs, services and activities. Please complete the form below to assist the OAS in determining your client's eligibility for disability services.

**Please note:**

- Any documentation provided to the OAS becomes part of the student's "educational record," pursuant to the Family Educational Rights and Privacy Act (FERPA). Under the privacy protection and access provisions of FERPA, the student has the right to inspect his or her own educational records, if requested.

**Use mouse or TAB key to proceed through the form, SHIFT+TAB to go back.**

| TO BE COMPLETED BY DIAGNOSTICIAN OR TREATING PROFESSIONAL | | | |
|---|---|---|---|
| **Student's Name:** | | **Date:** | |
| **Student's DOB:** | | | |
| **Practitioner Name & Title:** | | | |
| **Phone:** | | **Fax:** | |
| **Practice Name:** | | | |
| **Address:** | | | |
| **License or Certification Number:** | | **State:** | |
| **Specialty/qualification to make diagnosis:** | | | |
| **Date of last appointment:** | | | |

## SECTION I – DIAGNOSTIC INFORMATION

**Formal Diagnosis for injury:**

**Date of injury:** **Expected duration for injury:**

**<u>For concussions only</u>: Please describe the rationale or methodology used to reach the diagnosis.**

☐ **Symptom scale** ☐ **Neurological examination** ☐ **SCAT5**

**Symptoms that meet the criteria for diagnosis:**

**Current medication(s), dosage frequency, and adverse side effects:**

**Frequency of treatments/therapies, including recent or anticipated hospitalizations:**

## SECTION II - DETERMINATION OF DISABILITY

**Please discuss the impact of the diagnosis on the student's functioning in a college environment.**

**Which major life activities are substantially limited by the diagnosis?**

**How does the diagnosis impact or impair the student in the classroom/academic environment?**

**Please note:** To be eligible for services/accommodations, your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act and Amendments (ADAA).
These laws define a person with a **disability** as one who:

(1) has a physical or mental impairment which substantially limits one or more major life activities, or
(2) has a record of such an impairment, or
(3) is regarded as having such an impairment.

**Substantial Functional Limitation:** Client is restricted in comparison to the average person in the general population as to the conditions, manner, or duration under which major life activities can be performed.

**Major life activities** include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and functions including, but not limited to, the immune system, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, and reproductive functions.

**Accommodations:** Modification to policy, procedure, or practice which may include the provision of auxiliary aids and services designed to afford students with disabilities equal access to all programs and activities.

## SECTION III – PROFESSIONALLY RECOMMENDED ACCOMMODATIONS

**If appropriate, please discuss academic accommodations that you recommend for this student, based on the impact of the diagnosis on the student in the college environment. Please include a discussion/rationale for each recommended accommodation.**

**Please state alternatives to meet the documented need if the above requests cannot be met.**

**Please discuss the impact on the student's ability to function at Eastern if the accommodation(s) cannot be provided.**

**Provider's Signature:** _____ **Date:** _____

**To:**
AccessAbility@easternct.edu

Office of AccessAbility Services (OAS)
Wood Support Services, Room 201
Eastern Connecticut State University
83 Windham Street, Willimantic, CT
Phone: (860) 465-0189
Fax: (860) 465-0136

*Affix business card, stamp, or type in this box.*

**Name:**
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**Practice:**
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