The Office of AccessAbility Services  
Documentation of Disability Form for Temporary Injuries

Dear Provider:

You are being asked to provide documentation of disability for your client/patient. Please complete the form below and attach the appropriate supplemental documentation, if applicable. Thank you in advance for your support and cooperation in this matter.

Student’s Name: ______________________________________ Date: ___________________

Practitioner Name & Title: ____________________________________________________________________

Phone: ______________________________________________ Fax: ________________________________

Address: __________________________________________________________________________________

License or Certification Number: ___________________________ State: _________________________

Specialty/qualification to make diagnosis: _______________________________________________________

Date of last appointment: _______________________________

To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act (ADA). 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.

Accommodations are modifications 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 at Eastern.

The Office of AccessAbility Services (OAS) 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 appropriate and reasonable disability accommodations. Additional documentation may be required.
Please provide a complete medical diagnosis for the injury.

For concussions only: Please describe the rationale or methodology used to reach the diagnosis, as well as the symptoms that meet the criteria for diagnosis.

- Symptom scale
- SCAT3
- Neurological examination

Please specify when the student incurred the injury as well as the expected duration of the condition.

Do you regard this injury a temporary disability for the student? (See first page for definition of disability)

- Yes
- No
- Comments: __________________________

Please specify the major life activities that are frequently and substantially limited due to the student’s injury and explain how each limitation will specifically affect the student in the academic environment.

Major life activities include, but are not limited to, seeing, hearing, walking, talking, learning, breathing, sleeping, caring for one’s self, eating, bending, concentrating, thinking, communicating, working, or operation of a major bodily function.

Student is compliant with medical treatment for this injury:  
- Rarely
- Sometimes
- Often
- Unknown

- Comments: __________________________
Does this student take prescription medication for this injury? □ Yes □ No

If yes, which medications? Please note any side effects: __________________________________________
________________________________________

List all hospitalizations related to the injury. Please include dates and durations.

________________________________________
________________________________________

Please list the recommended academic and/or housing accommodations and a rationale for each accommodation (See first page for definition of disability). Please attach an additional page if more space is needed.

Accommodation: ________________________________

   Rationale: __________________________________________
   ___________________________________________________

Accommodation: ________________________________

   Rationale: __________________________________________
   ___________________________________________________

Accommodation: ________________________________

   Rationale: __________________________________________
   ___________________________________________________

Accommodation: ________________________________

   Rationale: __________________________________________
   ___________________________________________________
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.
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Additional comments:
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Provider’s Signature: ____________________________ Date: ____________________________

Please return form to:

Office of AccessAbility Services
Eastern Connecticut State University
185 Birch Street, Willimantic, CT 06226
Phone: (860) 465-5573
Fax: (860) 465-0136

Affix business card or apply business stamp within this box.