

UTM MARTIN

Office of Disability Services

MEDICAL ACCOMODATION FORM

Student name _____ Student ID _____ DOB _____

INTRODUCTION

Students who are seeking disability services through UTM's Office of Disability Services on the basis of a diagnosis of a medical impairment are required to submit documentation to verify eligibility under section 504 of the Rehabilitation Act of 1973 and the American with Disabilities Act of 1990 as amended. ***Under the Americans with Disabilities Act Amendments Act (ADA AA) revised in 2008, the term "disability" includes (a) a physical impairment that substantially limits one or more of the major life activities of an individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment.*** It is important to understand that a diagnosis of a medical condition in and of itself does not substantiate a disability. In other words, information sufficient to render a medical diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. Current and comprehensive documentation must be provided in order for a student to be eligible for support services and considered protected under the law.

Diagnosis by a licensed medical professional (a physician, a physician's assistant or an advanced practice nurse practitioner) with expertise in the area of concern is required based on the ICD-9/10 or the DSM-V. The healthcare provider must be an impartial evaluator who is not a family member nor in a dual relationship with the student.

ALL QUESTIONS BELOW MUST BE COMPLETED BY A QUALIFIED HEALTH-CARE PROVIDER

Note to Providers: This assessment should be current (six months to one year), include a clearly stated diagnosis, and must provide information about the significant impact to a major life function, including those expected for a post- secondary experience.

Health-care Provider Name _____

Credentials and State License # _____

ICD-9/10 or DSM-V Primary Diagnosis _____

1. How long have you been providing care to this student for this particular medical condition? _____

2. Date of most recent office visit: _____

3. Date of onset of current episode: _____

4. Current medications: _____

5. How has prescribed medication affected the student's functioning? _____

6. Current treatments, assistive devices and/or technologies: _____

7. What is the severity of the medical condition? ☐ Mild ☐ Moderate ☐ Severe

Please Explain: _____

8. What is the expected duration of the medical condition or disability?

☐ Long term: 3-12 months or longer

☐ Short term: 60-90 days

☐ Temporary: less than 60 days

Please Explain: _____

9. Is the medical condition: ☐ Acute ☐ Chronic ☐ Episodic?

Please explain: _____

10. Specify duration, stability, or progression of the condition or disability: _____

11. Describe the symptoms your patient presently displays: _____

12. Is there evidence that the symptoms currently meet ICD-9/10 or DSM-V criteria?

☐ Yes ☐ No

If yes, please describe symptoms: _____

13. Does the diagnosed condition rise to the level of a disability (according to the definition on page 1)? ☐ Yes ☐ No

If yes, functional impairment: _____

14. Please provide a brief summary of clinical and/or observational data(e.g. recent lab/bloodwork results, test results, ongoing medical therapy): _____

15. What is the current impact of (or limitations imposed by) the condition? _____

16. Provide recommendations for academic accommodations (e.g. extra time to complete exams). Include a clear rationale between key components of the diagnosed condition and the accommodation requested and any past accommodations and their effectiveness.

17. What parts of the student's academic social, or campus life experience will the student be unable to access without your recommendations? _____

CONTINUED ON NEXT PAGE...

18. Please check the extent to which major life activities are affected by the disabling condition:

Life Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know	Not Applicable
ADLs (e.g. hygiene /bathing, etc.)						
Attending class, labs, etc.						
Communicating: writing, verbal						
Concentrating						
Learning						
Living in an unstructured environment such as a residence hall (dorm)						
Living with roommate						
Regulating emotions						
Sleeping or waking						
Socializing						
Studying independently, in a group, etc.						
Other (please specify)						

Medical Provider Signature: _____ **Date** _____



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