



ACCESSIBILITY ACCOMMODATION DOCUMENTATION FORM

Student's Name: _____ Date of Birth: _____

Students with disabilities are eligible to request reasonable accommodations under the Americans with Disabilities Act of 1990, the Americans with Disabilities Act Amendments Act (ADA AA) of 2008, and Section 504 of the Rehabilitation Act of 1973 (as amended).

Individuals with disabilities are defined as persons with a physical or mental impairment which substantially limits one or more major life activities. This includes people who have a history of or regarded as having a physical or mental impairment. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning.

Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: learning disabilities, ADHD, chronic illness, blindness or visual impairment, deafness or hearing impairment, mobility impairments, alcoholism/drug addiction (in recovery), and psychiatric disorders.

Please use this form to provide documentation of your disability and recommendations for accessibility accommodations. The form must be filled out by a licensed health care professional familiar with your condition and history***. They must specialize in a field consistent with the diagnosed condition, i.e. the College will not accept documentation from a psychiatrist for a diagnosis of a gastrointestinal disorder. To avoid any conflict of interest, documentation must be provided by non-family health care providers.

AUTHORIZATION TO RELEASE INFORMATION:

I, _____, hereby authorize the exchange and release of the following confidential information below to Disability Services staff in the Office of Academic Skills at Washington College in support of my request for accessibility accommodations. I authorize my provider to supply additional information pertinent to this matter at the request of Disability Services staff and that updated information may be requested at any time. I understand that the information released by my provider will become part of my student record in the Office of Academic Skills. I agree that all information provided in support of my accommodation request will be reviewed by Disability Services staff to determine a response.

Student's Signature: _____ Date: _____

*** THIS FORM MUST BE SUBMITTED DIRECTLY TO THE OAS BY THE HEALTH CARE PROVIDER ***

Any questions may be directed to Liz Shirk, Disability Access Specialist & the Office of Academic Skills at lshirk2@washcoll.edu or 410.810.5799.



Dear Health Care Provider*:

Your patient/client, named below, is a student at Washington College and is requesting accessibility accommodations due to disability(ies). As part of the accommodation request process, current comprehensive documentation must be provided by an appropriately licensed health care professional* familiar with the student's condition and history. Please be aware that a diagnosis of a mental or physical condition does not automatically qualify the student for an accommodation.

The information which you provide will be reviewed by Disability Services staff in the Office of Academic Skills and become a part of the student's record in the Office of Academic Skills. Please complete each question on this form entirely. We request that you do not substitute attachments in response to questions; however, you may attach any other information you believe is relevant to the student's accommodation request. Please return the completed form via regular mail, email, or fax directly to the **Office of Academic Skills**. Thank you for assistance. The contact information is listed below:

Liz Shirk, Disability Access Specialist & the Office of Academic Skills
Washington College, 300 Washington Avenue, Chestertown, MD 21620
lshirk2@washcoll.edu | Phone: 410.810.5799 | FAX: 410.778.7884

Student's Name: _____ Date of Birth: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER*:

1. How long has this student been a patient/client in your care? _____

2. Provide the diagnosis(es) and date of diagnosis relevant to the request for accessibility accommodations (please use the appropriate diagnostic code, i.e. DSM-5, ICD-10):

3. Explain, in lay terms, the manifest symptoms and functional limitations of diagnosed mental or physical condition:

*The licensed health care provider must specialize in a field consistent with the diagnosed condition, i.e. the College will not accept documentation from a psychiatrist for a diagnosis of a gastrointestinal disorder. To avoid any conflict of interest, documentation must be provided by non-family health care providers.

- a. How long has the student had the condition(s)? _____
- b. What is the severity of the condition(s)? _____
- c. In the past year, how often have you treated this student for the condition(s)?

- d. How long is the condition(s) likely to persist? _____
- e. How frequently is the student affected by the condition(s)? Please check the frequency below:
 - infrequently, i.e. every few years
 - intermittently, i.e. flare-ups
 - frequently, i.e. monthly
 - very frequently, i.e. daily, weekly
- f. What factors improve the condition(s)?

- g. What factors exacerbate the condition(s)?

4. What daily activities (sleeping, eating, learning, walking, concentrating, standing, bending, communicating, thinking, etc.) are limited by the condition(s)? and how are they limited?

DAILY ACTIVITIES	LIMITATIONS

5. If pertinent, list all medications and therapies which the student is currently using to manage this condition.



- a. Are there any significant limitations to the student's functioning that are directly related to the prescribed medications and therapies?

6. List recommended accessibility accommodations and how each one might ameliorate the student's condition(s). These could be academic, i.e. extended testing time/distraction-reduced testing environment, modification to course attendance policies, notetaking services or non-academic, i.e. housing placement, meal-plan exemption, emotional support animals.

7. Please provide any additional information that you feel would be helpful in determining reasonable accessibility accommodations.

Certifying Licensed Professional

Printed Name: _____ Specialization: _____

Licensure Type/Classification: _____

License #: _____ State Issued by: _____

If outside of the U.S., list country and license information: _____

Address: _____

Phone: (____) ____ - ____ Email: _____@_____

Signature: _____ Date: _____

Any questions may be directed to Liz **Shirk**, Disability Access Specialist & the Office of Academic Skills at lshirk2@washcoll.edu or **410.810.5799**.