Disability Documentation Form

(Use for medical/psychological disabilities only)

- For **Learning Disabilities,** please do not complete this form, instead submit one of the following: psychological testing, evaluation summary, or Individualized Education Plan from high school
- For **Deaf/Hard of Hearing**, an audiogram or letter from an audiologist may be submitted instead of this form.

This form may be returned to the student or submitted directly to Utah Valley University Accessibility Services: **Email**: accessibilityservices@uvu.edu **Fax**: 801-863-8377, **Physical Mail**: Utah Valley University, Accessibility Services, 800 W. University Parkway, Orem, Utah, 84058

For questions, please contact UVU Accessibility Services at 801-863-8747 or accessibilityservices@uvu.edu

Student Information (to be completed by student)

Student Name:	
Student ID Number:	Phone Number:

Release of Information

By signing below, I hereby request and authorize the physician, counselor, psychologist, psychiatrist, Vocational Rehabilitation counselor, social worker, or educational institution listed on this form to furnish and/or discuss with Utah Valley University's Accessibility Services Department any information in their possession that provides a diagnosis and/or description of associated functional limitations and capabilities, as well as any information related to previous or current recommended accommodations, academic adjustments, or other work on my behalf.

Student Signature:	Date:

Provider Information

Name: OBJ	
Address: OBJ	Phone:
Credentials (specialty, license, certification):	

Disability Information (to be completed by a licensed/certified professional)

Date of Diagnosis:	Diagnosis/Health Condition (if applicable, include the DSM-V code):
Is the condition temporary or permanent? If temporary, what is the expected duration?	For pregnancy, please include the anticipated due date:
Please describe how the disability/medical condition impacts the student in an academic setting:	
If the condition includes any unpredicted, **episodic flare-ups**, please describe the frequency, severity, and duration:	
If applicable, please describe any side effects or negative impact due to the current medication:	
Please include any additional information that will assist us in determining accommodations that will provide access to an academic environment:	

By signing below, I verify that the diagnosis(es) and supporting information are accurate and current and that I am a qualified professional, certified/licensed to diagnose/treat the stated disability.

Provider Signature:	Date: