UVU Office of ACCESSIBILITY SERVICES
UTAH VALLEY UNIVERSITY

DISABILITY DOCUMENTATION FORM

Purpose of this Form

At Utah Valley University, the Office of Accessibility Services (OAS) approves academic accommodations for students with disabilities. Information provided on this form is only used to assist OAS in determining if this student's physical or mental health condition qualifies as a disability and what accommodations may be appropriate. For OAS' full documentation guidelines, please visit https://www.uvu.edu/accessibility-services/students/.

Instructions

This form should only be completed by a qualified professional who is licensed and properly credentialed to diagnose and treat the stated condition(s). This form should not be used to document learning disabilities.

How to Submit

Once this form has been completed it should be submitted to OAS. The student can upload this form to their student portal on Accommodate at https://uvu-accommodate.symplicity.com/ or it can be turned in to OAS directly by the student or healthcare provider via the contact information below:

Office of Accessibility Services
Utah Valley University
Losee Center, RM 312

Fax: 801-863-8377
Email: accessibilityservices@uvu.edu

STUDENT INFORMATION (UVU Student Completes This Section)	
Name:	Phone:
Student ID Number:	Date of Birth:

HEALTHCARE PROVIDER INFORMATION (Healthcare Professional Completes This Section)		
Name:	Credentials, specialty, license number and state):	
Address:		
Phone:	Fax:	Email:

DISABILITY ASSESSMENT
(To be completed by a qualified healthcare provider)

1. What is the specific diagnosis/health condition? Please also provide the relevant DSM-V or ICD code.

2. When was the diagnosis(es) made?	3. When did you last see and evaluate the student?
4. How long have you been treating the student?	5. What is the frequency of appointments?

6. How did you make the diagnosis(es)? What tools or methods were used to evaluate the student's symptoms?

7. Is this a temporary condition? If so, when will the student be cleared to resume normal activity?

8. What are the current symptoms that the student is experiencing?

9. Do the symptoms of the diagnosis(es) need to be reevaluated on a regular basis? If yes, how often?

10. **Functional Limitations**: Information on how the disability currently impacts the student is integral to identifying appropriate accommodations. How does the diagnosis(es) significantly affect the student's performance in academic settings? Provide clear details on how a major life activity is substantially limited by the disability, focusing on such activities which may pertain to an educational environment. Provide a clear sense of the severity, frequency and pervasiveness of the disability. How will any limitations associated with the disability impact the structure of individual courses, testing, program requirements, educational activities, practicum experiences, etc.?

DISABILITY ASSESSMENT (CONT.)
(To be completed by a qualified healthcare provider)

11. To qualify for accommodations, a major life function must be significantly, amply or substantially limited in the college environment. What major life activities does the diagnosis(es) and/or treatment plan affect? Check all that apply.

- ○ Caring for oneself
- ○ Performing manual tasks
- ○ Seeing
- ○ Hearing
- ○ Eating
- ○ Sleeping
- ○ Walking
- ○ Standing
- ○ Sitting
- ○ Reaching
- ○ Lifting
- ○ Bending
- ○ Speaking
- ○ Breathing
- ○ Learning
- ○ Reading
- ○ Concentrating
- ○ Thinking
- ○ Communicating
- ○ Working
- ○ Interacting with Others
- ○ Operation of a major bodily function

12. What is the current treatment or medication plan? How does the medication and/or treatment plan significantly affect the student's performance in academic settings?

13. **For Episodic Conditions Only:** If the student's condition involves episodic flare-ups that impact functioning, please describe any triggers of episodes, the frequency and duration of episodes, symptoms experienced during an episode, and care plan for management/recovery of the episode.

By signing below I am verifying that the diagnosis(es) and supporting information provided is accurate and current and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature:____ **Date:**__________________