Documentation of Disability Form
STUDENT ACCESSIBILITY AND ACCOMMODATION

1500 N. Warner St. #1096, Tacoma, WA 98416-1096, T: 253.879.3399 FAX: 253.879.3786

Email: saa@pugetsound.edu

Student's Name:_____ Student ID#: _____

D.O.B: _____ Town and State: _____ Telephone: _____

SAA 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.

By signing here you are permitting the professional who completed this form and Student Accessibility and Accommodation to discuss the information provided on this form and any other information needed to determine eligibility for disability accommodations. Please complete any release of information forms required by your treating professional.

Student Signature :_____ Date: _____

Dear diagnosing / treating professional,

Please complete the form below to assist SAA in determining appropriate and reasonable disability accommodations. SAA may contact you for clarifications or additional information.

Date of your first visit with the student? _____ How many times have you seen the student? ____

What is the diagnosis? _____

Who made the diagnosis? _____
Date of diagnosis _____

What are the clinical significant symptoms and signs?

_____
_____
_____

What are the major life activity impairments?

_____
_____
_____
_____

What are the procedures/assessments used to determine diagnosis and severity of symptoms

_____
_____
_____

How will the above limitation(s) interfere with this student's ability to participate in student life (e.g., academics, residence halls, recreation, etc.)?

_____
_____
_____
_____

Does this student take prescription medication for this condition? Yes No

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

_____
_____
_____
_____

Has this student been treated in an emergency room for this condition within the last year?

Has this student received in-patient treatment for this condition within the last year? Yes No

Recommended accommodation (must be clearly linked to functional limitations and medical needs):

_____
_____
_____
_____
_____

Professional's Signature: Affix business card or apply business stamp below

Date: _____

Please Print Name: _____

Address: _____

_____

License / Cert. #: _____ State: _____

Phone: _____

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