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GRAND VALLEY STATE UNIVERSITY
DISABILITY SUPPORT RESOURCES

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# DISABILITY DOCUMENTATION FORM:

## Chronic Health Condition

The office of Disability Support Resources (DSR) strives to ensure that qualified persons with chronic health conditions are accommodated, and if possible, that their accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Grand Valley State University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the University's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a chronic health condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

This form is designed to allow us to achieve these goals. Persons who wish to receive accommodations due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the person's condition, must have experience diagnosing and treating condition, and will be an impartial professional who is not related to the patient. **NOTE: Form may not be used as documentation for Assistance Animals.** Please complete all blanks on this document. If any information is left unanswered, this documentation will not be accepted.

*The Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment." Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.*

**General information**

Client name: Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____

Certifying Professional's Printed Name:_____

Credentials/Specialization:_____

License Type: _____

License #:_____ State _____ Exp. Date _____

Mailing Address:_____

City/State/Zip:_____

Phone: (_____)_____ Fax: (_____)_____

Email: _____

Attach Business Card Here

or

If Submitting Electronically,

Denote your Office Web Address

Office web address _____

**Diagnosis/Diagnoses:**

_____

_____

_____

Date of onset: _____ Date of diagnosis: _____

**Diagnostic Tools:** How did you arrive at your diagnosis/diagnoses? Please check any relevant items below:

☐ Interviews with the client ☐ Interviews with other persons

☐ Medical testing (e.g. MRI) ☐ Developmental history

☐ Medical history ☐ Neuro-psychological testing

☐ Psycho-educational testing ☐ Self-rated or interviewer rated scales

☐Other _____

**Prognosis:**

Expected Duration of Primary Condition: (Check One)

Permanent Temporary

Characteristics of Limiting Condition(s): (Check All That Apply)

☐Stable ☐Episodic ☐Slow Progression ☐Rapid Progression ☐Improving

Additional comments/information

_____

_____

**Medication, Treatment, and Prescribed Aids:**

What treatment, medication and prescribed aids are currently being to address the diagnosis/diagnoses above?

_____

_____

_____

Fully describe impact of medication side-effects that may adversely affect the client's academic or workplace performance:

_____

_____

_____

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please explain:

_____

_____

_____

Please record the client's appointment/treatment frequency:

_____

**Implications for Workplace or Academic/Student Life:**

| **Major Life Activity** | **Explanation of Impact**<br><br>Please describe the impact of your client's condition as it applies to each major life activity | **Recommendations for Accommodations and Services**<br><br>Please provide specific recommendations to address impacted major life activities |
|---|---|---|
| Concentration | | |
| Long Term Memory | | |
| Short Term Memory | | |
| Sleeping | | |
| Eating | | |
| Bodily functions (e.g. digestive, endocrine functions) | | |
| Self-Care | | |

| | | |
|---|---|---|
| Gross motor movements (lifting, bending, standing) | | |
| Fine motor movements (typing, writing) | | |
| Walking (e.g. how far?) | | |
| Motivation | | |
| Pain/pain management (how severe?) | | |
| Stress Management | | |
| Other (Explain): | | |
| Other (Explain): | | |

**Using the contact information on page one, print, sign below, and fax/send directly to Disability Support Resources.**

**Date: _____**

**Certifying Professional's Signature: _____**

**Signature denotes content accuracy, adherence to professional standards and guidelines on page 1 of this document.**