

## DISABILITY SUPPORT RESOURCES

Grand Valley State University

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[www.gvsu.edu/dsr](http://www.gvsu.edu/dsr)

### DISABILITY DOCUMENTATION FORM: LEARNING DISABILITIES

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.*

**Client Information (to be completed by the client)**

Last Name: \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Client's GVSU G#: \_\_\_\_\_

**Certifying Professional (to be completed by the certifying professional)**

Certifying Professional's Full Name: \_\_\_\_\_

Credentials/Specialization: \_\_\_\_\_

License Type: \_\_\_\_\_

License #: \_\_\_\_\_ State \_\_\_\_\_ Exp. Date \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Area Code: (\_\_\_\_\_) Phone Number \_\_\_\_\_

Fax Area Code: (\_\_\_\_\_) Fax Number \_\_\_\_\_

Email: \_\_\_\_\_

Please Attach Business Card Here

OR

If Submitting Electronically,

Denote your Office Web Address

Office web address: \_\_\_\_\_

**Diagnosis/Diagnoses: Please include DSM or ICD Codes and name of condition(s)**

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Date of onset: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

**Diagnostic Tools: How did you arrive at your diagnosis/diagnoses? Please check any relevant items below and attach assessment(s) to this form:**

- |   |   |
|---|---|
| <input type="checkbox"/> Interviews with the client | <input type="checkbox"/> Interviews with other persons            |
| <input type="checkbox"/> Behavioral observations    | <input type="checkbox"/> Developmental history                    |
| <input type="checkbox"/> Psycho-educational testing | <input type="checkbox"/> Neuro-psychological testing              |
| <input type="checkbox"/> High School IEP/504 Plan   | <input type="checkbox"/> Self-rated or interviewed related scales |
| <input type="checkbox"/> Other                      |   |

**Medication, Treatment, and Prescribed Aids**

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

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

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

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

<p><b>Major Life Activity</b></p>	<p><b>Explanation of Impact</b> Please describe the impact of your client's condition as it applies to each major life activity</p>	<p><b>Recommendations for Accommodations and Services</b> Please provide specific recommendations to address impacted major life activities</p>
Concentration		
Mathematics		
Reading		
Writing		
Staying on Task		
Completing Tasks		
Listening		
Taking Lecture Notes		
Managing Internal or External Distractions		
Time Management/ Organization		

Social Interactions		
Self-care (eating, sleeping, hygiene)		
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 Signature:** \_\_\_\_\_

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