

WCSU AccessAbility Services  
**Disability Provider Information Form**

You are being asked to provide documentation of a disability for your client, \_\_\_\_\_ . Please fill out this form and attach the appropriate supplemental documentation. Thank you in advance for your support and cooperation in this matter.

Practitioner Name/Title \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_  
License or certification number \_\_\_\_\_  
Specialty/qualification to make diagnosis \_\_\_\_\_  
Date of last exam/appointment with client \_\_\_\_\_

To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 and Amendment of 2009. These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. "Major life activities" are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, and functions including, but not limited to, the immune system, bladder, bowel, respiratory, circulatory and endocrine systems.

1. Diagnosis, date of diagnosis and expected duration of condition.
  
2. Description of symptoms associated with the condition.
  
3. Severity of condition \_\_\_Mild \_\_\_Moderate \_\_\_Severe
  
4. Please check all functional limitations that are substantially limited:  
\_\_\_ Walking \_\_\_Hearing \_\_\_Seeing \_\_\_Working \_\_\_ Sleeping \_\_\_ Caring for self  
\_\_\_ Interacting with others \_\_\_Learning (including memory/concentration)  
\_\_\_ Performing manual tasks \_\_\_ Other, please describe:
  
5. List current medication(s), dosage frequency, and adverse side effects.

6. List therapies, frequency of treatments including recent or anticipated hospitalizations.
  
7. Please explain how each functional limitation will specifically affect your client in the academic environment.
  
8. Please suggest reasonable accommodations. Each recommendation must be supported by the diagnosis. Please explain the rationale for each suggested accommodation relating it to a specific functional limitation.
  
9. Please state alternatives to meet the documented need if the first request cannot be met.
  
10. Please discuss the impact on your client's disability if the accommodation cannot be granted.
  
11. Additional comments:

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Signature of specialist

Date

*The Coordinator of AccessAbility Services in consultation with school officials will make all final decisions on which accommodations will be granted.*

**Please return the completed form and supplemental documentation to:**

**AccessAbility Services  
Western Connecticut State University  
181 White St  
Danbury, CT 06810  
203-837-8225 (voice) \* 203-837-8848 (fax)**