

Accessibility Services Assessment Form

The Office of Academic Resources & Accessibility Services provides academic services and accommodations for students with diagnosed disabilities. Students are required to provide documentation that verifies that a diagnosed disability/disorder meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act - Amendments Act of 2008 (ADAAA).

These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly states how the disability/disorder functionally limits the student in an academic environment and demonstrates that one or more accommodations is needed to achieve equal access.

TO BE COMPLETED BY STUDENT

Student Name: _____ F00#: _____

Campus/Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ CUAAs Email: _____

TO BE COMPLETED BY LICENSED MEDICAL PROFESSIONAL

Please provide responses to the following items by typing or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.

1. Diagnosis(es): _____

2. Date of Diagnosis: _____

3. What instruments/procedures were used to diagnose the disorder/disability?

4. Please describe the presenting symptoms of this disorder/disability?

5. Is this student currently taking medication for this disorder/disability (Circle One)? Yes No

If yes, please describe any possible side effects of the medication: _____

6. Please describe the impact of this disorder/disability on the student's academic performance.

7.If applicable, please state specific academic accommodation recommendations for this student, and a rationale as to why the accommodation is necessary.

<i>Accommodation Recommendations</i>	<i>Rationale</i>

CERTIFIER INFORMATION/CREDENTIALS

Name: _____ Date: _____

Medical Specialty: _____

License (Type, State, #) _____

Address: _____

Phone: _____ Email: _____

Clinician's Signature: _____ Printed Name: _____

Please send this completed form and any additional information to:

Jan Chapman, CUW Director of Academic Resources & Accessibility Services
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Concordia University Wisconsin
Office: Luther Hall 200
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