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: ___________________________ CUAA 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?

____
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____

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

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____
____
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5. Is this student currently taking medication for this disorder/disability (Check 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.

Accommodation Recommendations	***Rationale***

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:

Kimberly R.Bentley
Assistant Director of Academic Resources & Accessibility
Services Concordia University Ann Arbor
Office: Zimmerman Library, 1st. Floor
Email: kimberly.bentley@cuaa.edu
Phone: 734-995-7582   Fax: 734-995-4819