Labouré
COLLEGE OF HEALTHCARE

Disability Disclosure Form

This form must be completed by the licensed clinician or provider **who is treating or assessed this student for the diagnosisidentified** in this document. *In order to best serve the student, please thoroughly complete all requested information.*

Student's Name: _____

Clinician's Name: _____

Area of Specialty: _____ Phone #: _____

The person named on this form is requesting services from Labouré Access & Accommodations. The Office offers services to students who are considered disabled under the mandates of the Americans with Disabilities Amendments Act of 2008 (ADAAA).

By completing this document, I verify that the person named in this document has a substantially limiting disorder that meets the ADAAA disability criteria noted below. (A letter on Provider's letterhead with the requested information may be substituted for this form.)

Under the ADAAA definition, a person with a disability is one with a physical, mental, emotional or chronic health impairment that substantially *limits one or more major life activity* such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction *(this is not an exhaustive list)*.

Please thoroughly complete this form to document the substantial limitations that are linked to this disability. Please attach all relevant documentation including pertinent testing and diagnostic assessments.

1. Diagnosis/Description of Disability: _____
2. Please provide full DSM or ICD-9 code: _____
3. Initial Date of Diagnosis: _____
4. Date of Last Clinical Contact: _____
5. The extent of the disability is: ☐ Mild ☐ Moderate ☐ Severe
6. Expected duration of medical condition or disability ☐ Long term ☐ Short-term ☐ Temporary
7. What is the frequency and duration of symptoms of the student's condition?

☐ Daily ☐ 1-3/week ☐ 1/week ☐ 1/month ☐ 1-3/year ☐ Seasonal

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Please describe the ***substantially*** limiting symptoms which impacts this student's functional abilities in the following areas:

a. In the classroom or lab. *Please describe the current impact of this student's disability on their ability to perform in-class or lab work. Please consider, as relevant, the impact on tasks including, but not limited to: paying attention to lecture, taking notes, responding to oral or written questions, participating in group work, and following instructions.*

b. During exams/tests/quizzes/timed class work. *Please describe the current impact of this student's disability on their ability to perform during testing or on times work. Please consider, as relevant, the impact on tasks including, but not limited to: maintaining concentration, disregarding distractions, organizing responses, and speed of responses.*

Please describe the current treatment and medication regimen (including treating clinicians, frequency of treatment, medications, and side effects):

Clinical Signature: _____ Date: _____