Lake Superior State University
Office of Accessibility Services

Disability Documentation Form 2018-19

1. Name: ______________________________________  Birthdate: __________
   (First)              (Middle)                (Last)

2. Diagnosis/Diagnoses: (Please include the DSM or ICD Codes)
______________________________________________________________________
______________________________________________________________________

3. Date of Diagnosis/Diagnoses: __________________________________________

4. Check Any Diagnostic Tools Used: (Attach Relevant Assessment Results to this Form)
   □ Interview with the individual   □ Psycho-educational testing
   □ Self Rated Scales               □ Neuropsychological testing
   □ Interviewer Scales              □ IEP or 504 Plan
   □ Observations of Behavior        □ Developmental History
   □ Other ____________________________

5. Describe functional limitations and/or behavioral manifestations (i.e. limited mobility, challenges associated with reading/writing/mathematical computations, difficulty understanding verbal directions, issues with memory or concentration, issues related to pain management, difficulty moderating mood, inability to tolerate certain stimuli, etc.)
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

6. Please recommend educational accommodations (i.e. extended test time, distraction reduced testing environment, priority/reserved seating, tests read aloud, etc.).

<table>
<thead>
<tr>
<th>Functional Limitations/Behavioral Manifestations</th>
<th>Recommendations for Accommodations and Services</th>
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Double sided, please complete reverse side of form.

5/18/18
7. List any current treatment and/or prescribed aids utilized for the above listed diagnosis/diagnoses.
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

8. Are there any special considerations? (i.e. side effects of medication)
______________________________________________________________________
______________________________________________________________________

9. If applicable, what is the recommended re-evaluation time period? _____________

10. Certifying Professional-Please Print and Sign Below.

Name, Title and Credentials
_____________________________________________________________________
Signature ______________________ Date ______________________

Agency Name
_____________________________________________________________________
Agency Address
_____________________________________________________________________
Agency Phone ______________________ Agency Fax ______________________

Please Mail, Hand Deliver, Email or Fax
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Email: accessibility@lssu.edu  Fax: (906) 635-2193  Phone: (906) 635-2355

For Office Use Only:

<table>
<thead>
<tr>
<th>Date Received:</th>
<th>How Received:</th>
<th>Diagnosis/Diagnoses Documentation Complete?</th>
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<tbody>
<tr>
<td>_____ / _____ / _____</td>
<td>Mail</td>
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<td>First Semester Registering w/OAS:</td>
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If No, What Else Is Needed:
_____________________________________________________________________
Date/How Additional Documentation Received:
_____________________________________________________________________

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