Midwestern University

UNIVERSAL THIRD-PARTY DISABILITY DOCUMENTATION

Midwestern University Student Services

Dear Provider:

The following student _____ , Student ID_____

DOB _____ has requested accommodations through Student Services at Midwestern University. To determine eligibility and appropriateness of accommodations afforded by applicable law, documentation is needed to verify the student's diagnosis(es), as well as the impact of this diagnosis on one or more major life activities.

Please complete all sections of this form and provide the completed form to the student. The student will provide the completed form to **disability_accommodations@midwestern.edu.**

Any documentation provided to Student Services remains confidential. No information concerning accommodations or documentation will be released or discussed without written consent from the student.

Your thoughtful and thorough responses to the questions are appreciated and important for helping us engage with the student in the interactive process.

Thank you in advance for your cooperation with this process.

Sincerely,

MWU Student Services

Midwestern University

RELEASE OF INFORMATION

TO BE COMPLETED BY THE STUDENT:

I, _____ , hereby authorize the release of the following information to Student Services at Midwestern University for the purpose of determining my eligibility for accommodations. If it is determined that I am eligible, the information will be utilized to establish reasonable accommodations.

Signature of Student	ID Number	Date	DOB

TO BE COMPLETED BY THE PROVIDER:

Name of Student:_____ DOB:_____

Evaluator

The professional submitting the documentation must be qualified to conduct the assessment and make a diagnosis. The professional may not be related to the student.

Name (Printed):

Date:

Degree:

Medical Specialty:

License Number:

State of Issue:

Address:

Phone Number:

Fax:

Email:

Signature:

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DIAGNOSTIC INFORMATION

Primary Diagnosis:_____ Date of Diagnosis: _____

Secondary Diagnosis:_____ Date of Diagnosis: _____

Are there additional diagnoses our office should be aware of? If so, please list below.

Is primary diagnosis expected to be valid for 6 months or longer?

- ○ Yes
- ○ No (Please list expected duration of diagnosis)

How was this diagnosis determined?

How was this diagnosis concluded? (Please check all that apply?)

- ☐ Interview with patient
- ☐ Interview with relative/ supporter of patient
- ☐ Behavioral Observations
- ☐ Educational History
- ☐ Developmental History
- ☐ Medical Records
- ☐ Testing (e.g., Neuro-psychological, educational, psychological)
- ☐ Other (please specify)

CLINICAL ASSESSMENT

Date Student First Seen:

Date Student Last Seen:

Do you see this student regularly?

If so, how often?

Date of Diagnosis:

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DIAGNOSIS

Please give a clear statement of the physical/medical/sensory/psychological/neurodiverse/learning disability, including condition, manner and duration.

Please indicate disability status:

○ Permanent ○ Temporary ○ Long Term Temporary (Up to 6 months)

MAJOR LIFE IMPACTS

Please rate the level of impact of the diagnosis(es) on the following major life activities based on a scale of 1-10. **(1= least impact; 5= Moderate impact; 10= Most impact). Please indicate all that apply. For activities not impacted, please indicate "N/A"**

Concentration _____	Physical Mobility _____	Breathing _____
Memory _____	Learning _____	Managing distractions
Socialization _____	Reading _____	Internal / External _____
Speaking _____	Processing _____	Executive functioning _____
Hearing _____	Communicating _____	Organization _____
	Sleeping _____	Other: _____

Please use the space below to include further rationale or other areas of note as relevant.

Does the impact of the disability fluctuate in its impact on major life functions?

○ Yes ○ No ○ Other (please explain)

If the impact of the disability fluctuates, what factors are likely to contribute to fluctuations?

Please describe how the above limitations may manifest in the university environment and relative to the requirements of the student's studies.

In the Classroom/Didactic Environment

In the Testing Environment

While Completing Assignments

In an applied setting, such as a lab or clinic placement

In on-campus housing or other campus environments

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TESTING

Please list any tests performed that would help to evaluate the student's ability to perform in academic settings (classroom, lab, simulation or clinical settings) or extracurricular settings. **Copies of the tests should be included as part of the documentation.**

Test	Date Administered

TREATMENT/INTERVENTION PLAN

Give a detailed outline of the student's current treatment plan, including medications and therapy. If medication is part of the treatment plan, please list the medication, dosage, frequency of use and possible side effects. How often is the efficacy of the treatment plan assessed? If the student is responding positively, to what extent does the treatment plan alleviate the need for accommodations within the academic or extracurricular setting?
Attach additional sheets if necessary.

Is the student's treatment/intervention effective currently?

- ○ Yes
- ○ No
- ○ Other (please explain)

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POTENTIAL ACCOMMODATION CONSIDERATIONS

Please list the specific potential academic or extracurricular accommodations you recommend for this student, and a rationale for the basis of the recommendation(s).

Accommodation Recommended	Rationale

Do the recommended accommodations above address all known disabilities and related limitations?

- ○ Yes
- ○ No

Will the student's disability require possible flexibility in attendance?

- ○ Yes
- ○ No
- ○ Unable to assess

If yes, please indicate the reason. *

- ☐ Due to symptoms experienced
- ☐ As a result of side effects of medication or treatment
- ☐ For treatment of the disability

*Please note - There may be limitations on the number of absences a student is allowed based on class, lab, and or clinical/field placement requirements.