UT MARTIN
Office of Disability Services

MEDICAL ACCOMODATION FORM

Student name_____Student ID_____ DOB_____

INTRODUCTION

Students who are seeking disability services through UTM's Office of Disability Services on the basis of a diagnosis of a medical impairment are required to submit documentation to verify eligibility under section 504 of the Rehabilitation Act of 1973 and the American with Disabilities Act of 1990 as amended. ***Under the Americans with Disabilities Act Amendments Act (ADA AA) revised in 2008, the term "disability" includes (a) a physical impairment that substantially limits one or more of the major life activities of an individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment.*** It is important to understand that a diagnosis of a medical condition in and of itself does not substantiate a disability. In other words, information sufficient to render a medical diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. Current and comprehensive documentation must be provided in order for a student to be eligible for support services and considered protected under the law.

Diagnosis by a licensed medical professional (a physician, a physician's assistant or an advanced practice nurse practitioner) with expertise in the area of concern is required based on the ICD-9/10 or the DSM-V. The healthcare provider must be an impartial evaluator who is not a family member nor in a dual relationship with the student.

ALL QUESTIONS BELOW MUST BE COMPLETED BY A QUALIFIED HEALTH-CARE PROVIDER

Note to Providers: This assessment should be current (six months to one year), include a clearly stated diagnosis, and must provide information about the significant impact to a major life function, including those expected for a post- secondary experience.

Health-care Provider Name_____

Credentials and State License #_____

ICD-9/10 or DSM-V Primary Diagnosis_____

1. How long have you been providing care to this student for this particular medical condition?_____

2. Date of most recent office visit:_____

3. Date of onset of current episode:_____

4. Current medications:_____

5. How has prescribed medication affected the student's functioning?_____

_____

6. Current treatments, assistive devices and/or technologies:_____

_____

7. What is the severity of the medical condition?____Mild____Moderate____Severe

Please Explain:_____

_____

_____

8. What is the expected duration of the medical condition or disability?

____Long term: 3-12 months or longer

____Short term: 60-90 days

____Temporary: less than 60 days

Please Explain:_____

_____

_____

9. Is the medical condition: _____Acute _____Chronic _____Episodic?

Please explain:_____

_____

_____

10. Specify duration, stability, or progression of the condition or disability:_____

_____

_____

11. Describe the symptoms your patient presently displays:_____

_____

12. Is there evidence that the symptoms currently meet ICD-9/10 or DSM-V criteria?

____Yes____No

If yes, please describe symptoms:_____

_____

_____

_____

13. Does the diagnosed condition rise to the level of a disability (according to the definition on page 1)?____Yes____No

If yes, functional impairment:_____

_____

_____

14. Please provide a brief summary of clinical and/or observational data(e.g. recent lab/ bloodwork results, test results, ongoing medical therapy):_____

_____

_____

_____

15. What is the current impact of (or limitations imposed by) the condition?_____

_____

16. Provide recommendations for academic accommodations (e.g. extra time to complete exams). Include a clear rationale between key components of the diagnosed condition and the accommodation requested and any past accommodations and their effectiveness.

_____

_____

17. What parts of the student's academic social, or campus life experience will the student be unable to access without your recommendations?_____

_____

_____

CONTINUED ON NEXT PAGE...

18. Please check the extent to which major life activities are affected by the disabling condition:

Life Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know	Not Applicable
ADLs (e.g. hygiene /bathing, etc.)						
Attending class, labs, etc.						
Communicating: writing, verbal						
Concentrating						
Learning						
Living in an unstructured environment such as a residence hall (dorm)						
Living with roommate						
Regulating emotions						
Sleeping or waking						
Socializing						
Studying independently, in a group, etc.						
Other (please specify)						

Medical Provider Signature:_____**Date**_____

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OFFICE OF DISABILITY SERVICES

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