Disability Documentation Form

Student Disability Services (SDS) at the University of Tennessee, Knoxville, seeks to establish an inclusive environment where every aspect of the university experience is readily accessible for all students without barriers or bias. The student and SDS partner to identify strategies, including accommodations, that can ***reduce or remove barriers to access within the academic and campus environments.*** This form was created to facilitate the individualized review of a student's need for requested accommodations and to assist SDS in developing an appropriate accommodation plan together with the student.

The information submitted to SDS should reflect the most currently available information. This Disability Documentation Form should be:

a) **Completed by a qualified professional.** The diagnosing professional should have an established treatment relationship with the student and may not be related to the student.

b) **Completed as clearly and thoroughly as possible.** Incomplete responses and illegible handwriting may require additional follow-up that could delay the review process.

c) **Supplemented with any evaluative reports that may provide a more complete understanding of the student's accommodation needs, if applicable.** Evaluative reports may include comprehensive diagnostic reports such as psychoeducational or neuropsychological reports. Please do not provide case notes or rating scales without a narrative that explains the results.

d) **Submitted to Student Disability Services.** All documentation received will be held with strict confidentiality as a student record.

Please mail, email, or fax information to Student Disability Services at:
1534 White Avenue/199 Blount Hall
Knoxville, TN 37996-3107
Email: sds@utk.edu
Fax: (865) 974-9552

Student Disability Services
1534 White Avenue/199 Blount Hall, Knoxville, TN 37996-3107
865-974-6087 (p)   865-974-9552 (f)
sds.utk.edu

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Flagship Campus of the University of Tennessee System ut

Today's Date: _____

Student Name: _____ Birthdate: _____

1. Date of first contact with this individual: _____

   Date of last contact with this individual: _____

2. Diagnosis(es): *Please include diagnostic specifiers and ICD-10 or DSM-V diagnostic codes, if applicable.*

   Primary Diagnosis: _____

   Secondary Diagnosis: _____

   Tertiary Diagnosis: _____

   Quaternary Diagnosis: _____

3. Describe any potential side effects of prescribed medication.

4. If any of the student's diagnoses are not expected to be permanent, what is the anticipated duration of the impact(s) of the disability?

5. Impact of Disability: *To assist SDS in understanding the relevant impacts of the student's disability on common tasks that will be part of their academic and campus experience,* **please specify in the following table the degree of impact <u>without mitigating measures</u>** *(e.g., medication, assistive technology, etc.) in a postsecondary setting.*

Major Life Activities	Degree of Impact (Check degree of impact for each activity)			
	None	**Mild**	**Moderate**	**Substantial**
Performing manual tasks	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Communicating	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Memorizing	☐	☐	☐	☐
Listening	☐	☐	☐	☐
Observing	☐	☐	☐	☐
Sustained reading	☐	☐	☐	☐
Sustained writing	☐	☐	☐	☐
Interacting with others	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Operation of major bodily functions (e.g., digestive, bowel, bladder, immune, respiratory, etc.)	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

6. What specific symptoms might affect the student's access to academic and campus experiences?

7. Are any of the student's symptoms episodic or cyclical in nature, as opposed to fairly constant? If yes, please explain.

8. Share any **specific** recommendations regarding accommodations that provide **equitable access** to a postsecondary environment for this student.

Healthcare Provider Information

By signing this form, the healthcare professional certifies that they are an appropriately credentialed or licensed professional trained in the assessment and treatment of the diagnosis(es) described herein.

Provider Name (Print): _____

Provider Signature: _____

License or Certification #: _____

Address: _____

Phone: _____ Fax: _____