Bay Atlantic University
Disability Documentation Form

In order for us to provide disability-related services and accommodation, we need to establish that this individual has a physical or mental impairment that substantially limits one or more of the major life activities, understand the impact of that disability in higher education settings, and determine reasonable accommodations and services that may assist in ameliorating these impacts.

Today's Date: _____

Individual's Name: _____

Program of Study: _____

Diagnosis (if known)/Description of the Functional Impact (required)

1. Please state the condition/diagnosis:

_____

_____

2. How did you arrive at your diagnosis? Please check all relevant items below:

Structured or Unstructured interview	□	Medical tests	□
Interviews with others	□	Medical History	□
Behavioral Observations	□	Developmental History	□

3. Describe the relevant, current impact of the condition on the student in a higher education setting (academic, housing, dining, transportation, social, etc).

_____

_____

_____

_____

_____

History and Prognosis (to the degree known)

	Month	Date	Year		Other
Date condition was first diagnosed				[redacted]	
Date individual first seen for the condition					
Date most recently seen for this condition					
Expected duration of condition				Permanent	
How long do you anticipate the impact	3 months	6 months	1 year	More than one year	
Anticipated return to work date				TBD at a later date	
The condition is	stable	improving	worsening	cyclically variable	
The prognosis is	poor	fair	good	excellent	
How often is this individual seen	weekly	monthly	3-6 months	yearly	

4. If the individual is currently taking medication that has side effects and any impact on relevant functioning, please describe below. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic/Work Impact	Persistence of Symptoms

5. Please recommend any specific accommodations or services to address the functional limitations identified. This information will be factored into the process of determining reasonable accommodations.

_____

_____

_____

_____

6. Do you anticipate any changes in the individual's condition/medication? No Yes Please explain.

_____

_____

7. Is the individual working with another physician or specialist to treat the condition(s)? No Yes Please explain and indicate who else if known.

_____

_____

PLEASE TYPE OR PRINT CLEARLY

Name/Title

_____

Signature_____ Date: _____

License/Certification #_____ State _____

Address _____

City, State, Zip Code_____

Phone _____ Email: _____