

**DOCUMENTATION OF DISABILITY**

Disability Services' goal is to provide reasonable and effective accommodations for students with qualifying disabilities to support equal access to their education.

Eligibility for accommodations is determined by the individual's qualifications as a person with a disability. A disability is a physical or mental impairment that substantially impairs or restricts one or more major life activities. Documentation must be dated within the last three years.

**\*\*\*To be filled out by a medical doctor, licensed mental health counselor, or licensed psychologist\*\*\***

**Student Name & Date of Birth:** \_\_\_\_\_

**Name of Clinic/Medical Office & Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Initial Date of Diagnosis(es):** \_\_\_\_\_ **Most Recent Assessment Date:** \_\_\_\_\_

**Diagnosis(es):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*The diagnosis(es) must clearly state a DSM-5 or ICD-10 diagnosis, and also must verify interference with a major life activity.*

*Please check all major life activities affected by the above listed diagnoses:*

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Caring for oneself      | <input type="checkbox"/> Hearing   |
| <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> Breathing |
| <input type="checkbox"/> Walking                 | <input type="checkbox"/> Learning  |
| <input type="checkbox"/> Seeing                  | <input type="checkbox"/> Working   |

**Current Symptoms:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Treatment Strategies and Prognosis:**

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**Summary of the functional limitations of the diagnoses and the impact that medication and/or treatment has on educational functioning:**

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**Suggested Accommodations:**

Diagnosticians can provide suggestions for reasonable accommodations appropriate at the post-secondary level of education. Such accommodations should be supported by both the assessment results and by the diagnosis(es). The Director of Disability Services will evaluate recommendations on a case-by-case basis. Accommodations must be reasonable and cannot fundamentally alter the basic nature or essential elements of an institution's courses or programs.

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**Diagnostician's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Diagnostician's Title/Credentials:** \_\_\_\_\_

**Diagnostician's Signature:** \_\_\_\_\_

***Please mail, e-mail, or fax the above information to:***

**ATTN:**

*Director of Disability Services  
Inver Hills Community College  
2500 80<sup>th</sup> Street East  
Inver Grove Heights, MN 55076*

**PHONE:** 651-450-3884

**FAX:** 651-450-3677

**EMAIL:** [disabilityservices@inverhills.edu](mailto:disabilityservices@inverhills.edu)

**\*\*\*Please remember to complete and send back both sides of this document\*\*\***