



### DISABILITY DOCUMENTATION FORM

The student named below has requested accommodations from Student Accessibility Services (SAS) at the University of Maine at Machias. In order to determine eligibility and to provide accommodations, we require documentation of the student's disability.

This form is to be completed by the treating clinician, psychiatrist, social worker, or medical provider only. Forms completed by the student or parent will not be considered documentation of disability. Once completed it can be returned to us via email at [ummdisability@maine.edu](mailto:ummdisability@maine.edu), or regular mail. The information you provide will not be filed with the student's other educational records, but will be kept in the student's file at SAS, where it will be held confidential. In addition to the requested information, please attach any other information you think would be relevant to the student's accommodations. Please contact us if you have questions or concerns. Thank you for your assistance.

Student Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Date student was last seen: \_\_\_\_\_

Student is seen:  Occasionally       Regularly       Only as needed

*Please fill out all applicable sections below*

**DSM-5 Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_

**ICD -10 Codes & Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_

What is the severity of the condition? Please check one:  Mild       Moderate       Severe

Please explain: \_\_\_\_\_  
\_\_\_\_\_

1. In addition to the DSM-5 / ICD-10 criteria, how did you arrive at your diagnosis? Please check all relevant items below, and *add a descriptive statement for each item checked*. This information will help us determine appropriate accommodations and services for the students.

Structured or unstructured interviews with the person themselves:

Interviews with other persons:

Behavioral observations:

Developmental history:

Family history:

Educational history:

Medical history:

Neuro-psychological testing. Please attach a copy of the testing.

Psycho-educational testing. Please attach a copy of the testing.

Standardized or un-standardized rating scales.

Other (please specify):

2. **Major Life Activities Assessment:** Please check which of the following major life activities listed below are affected by the student’s disability and indicate the severity of the limitations.

<b>Life Activity</b>	<b>No Impact</b>	<b>Mild Impact</b>	<b>Moderate Impact</b>	<b>Severe Impact</b>	<b>Don't Know</b>
Concentrating					
Memory					
Self-Care					
Speaking					
Learning					
Reading					
Communicating					
Sleeping					
Managing Internal Distractions					
Managing External Distractions					
Regular Class Attendance					
Meeting Assignment Deadlines					
Stress Management					
Organization					

3. **ADD/ADHD Diagnosis and history:** If student has a diagnosis of ADD/ADHD please describe evidence of inattention and/or hyperactivity currently and in years prior (e.g. difficulty sustaining attention in tasks or activities, difficulty with executive functioning, unable to sit still, difficulty following directions, impulsivity etc.).

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4. Is the student currently receiving therapy or counseling?

Yes       No       Not sure

5. Please provide relevant information regarding the student’s psychological, educational and medical history (e.g. poor grades in school due to problems with executive functioning, history of risk or dangerous activities, history of depressed mood etc.) and any specific symptoms/functional limitations that might affect the student in an academic setting.

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6. Has medication been prescribed or is treatment ongoing? Please any list current medication(s) that the student is prescribed including dosage, frequency of use, adverse side effects, and the effectiveness of the medication.

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7. State specific recommendations regarding the academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary (e.g. if a note taker is suggested, state the reason for this request related to the student's diagnosis).

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**HEALTHCARE PROVIDER INFORMATION**

(Please sign & date below and completely fill in all other fields)

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Name (Print): \_\_\_\_\_

Title: \_\_\_\_\_ License: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_