Accessibility Services Assessment Form

The Office of Academic Resources & Accessibility Services provides academic services and accommodations for students with diagnosed disabilities. Students are required to provide documentation that verifies that a diagnosed disability/disorder meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act - Amendments Act of 2008 (ADAAA).

These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly states how the disability/disorder functionally limits the student in an academic environment and demonstrates that one or more accommodations are needed to achieve equal access.

TO BE COMPLETED BY STUDENT

Student Name: _____F00#:_____

Campus/Home Address: _____

City: _____ State: _____ Zip Code:_____

Phone Number: _____ CUW Email:_____

TO BE COMPLETED BY LICENSED MEDICAL PROFESSIONAL

Please provide responses to the following items by typing or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.

1. Diagnosis(es):_____

2. Date of Diagnosis: _____

3. What instruments/procedures were used to diagnose the disorder/disability?

_____
_____
_____
_____

4. Please describe the presenting symptoms of this disorder/disability?

_____
_____
_____
_____

5. Is this student currently taking medication for this disorder/disability (Check One)? ☐ Yes ☐ No

If yes, please describe any possible side effects of the medication:_____
_____

6. Please describe the impact of this disorder/disability on the student's academic performance.

_____
_____

_____

_____

7. If applicable, please state specific academic accommodation recommendations for this student, and a rationale as to why the accommodation is necessary. Accommodations are NOT retro-active, they are applied at the time of approval and moving forward.

Accommodation Recommendations	***Rationale***

CERTIFIER INFORMATION/CREDENTIALS

Name:_____ Date:_____

Medical Specialty:_____

License (Type, State, #)_____

Address:_____

Phone:_____ Email:_____

Clinician's Signature:_____ Printed Name:_____

Please send this completed form and any additional information to:

Janis C. Chapman
Director of Academic Resources & Accessibility Services
Concordia University Wisconsin - Ann Arbor
Email: janis.chapman@cuw.edu
Phone: 262-243-4299 Fax: 262-243-2999