Earlham
COLLEGE
Office of Disability & Accessibility Services

**Submit form to:**
**801 National Road West**
**Richmond, Indiana, 47374**
**765.983.1341 (Phone)**
**765.973.2120 (Fax)**
**odas@earlham.edu**

# Certification of Disability Status and Accommodation

*The student named below is requesting services from the Office of Disability Services at Earlham College. The provision of reasonable and appropriate accommodations for students with psychological and/or physical disabilities necessitates comprehensive documentation detailing the functional impact of the disabling condition(s). This form must be completed by a mental health or medical healthcare provider and is intended to assist Disability Services personnel in determining eligibility for reasonable accommodations. The information you provide will not become a part of the student's educational record but will be kept in a separate, confidential file. Please submit any additional documentation relevant to the processing of the student's request with this form.* **Please print legibly and complete in detail all sections of this form. Where not applicable, write N/A.**

**Date of Completion** (mm/dd/yyyy)**:** _____

**Student Legal Name:** _____ **DOB** (mm/dd/yyyy): _____

**Preferred/Chosen Name:** _____

**Legal definitions**

The *Fair Housing Act of 1968*, 42 U.S.C. 3601 et seq., prohibits discrimination on the basis of disability in all types of housing transactions. The FHA defines persons with a disability to mean those individuals with mental or physical impairments that **substantially limit one or more major life activities**.

The *Americans with Disabilities Amendments Act of 2008* (ADAAA) defines major life activities as: caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Under the ADAA major life activities has been expanded to include major bodily functions. These are functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

**Information about the student's disability**

1. Does the student have a disability under these definitions? ☐ Yes ☐ No

If no, please explain: _____

_____

If yes, please provide us with the following diagnostic information:

Primary Diagnosis including DSM/ICD code(s): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe Date of diagnosis (mm/dd/yyyy): _____

Secondary Diagnosis including DSM/ICD code(s): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe Date of diagnosis (mm/dd/yyyy): _____

Tertiary Diagnosis including DSM/ICD code(s): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe Date of diagnosis (mm/dd/yyyy): _____

Quaternary Diagnosis including DSM/ICD code(s): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe Date of diagnosis (mm/dd/yyyy): _____

Quinary Diagnosis including DSM/ICD code(s): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe Date of diagnosis (mm/dd/yyyy): _____

Other Condition(s) That May Be a Focus of Clinical Attention represented by V/Z code(s):

_____

_____

_____

Psychosocial or environmental stressors: _____

_____

_____

2. Is the student currently under your care? ☐ Yes ☐ No

   Date of first contact (mm/dd/yyyy): _____

   Date of last contact (mm/dd/yyyy): _____

3. Please briefly describe relevant developmental, historical, and/or familial data:

_____

_____

_____

_____

_____

_____

4. Please state the medication(s) or treatment plan currently prescribed:

_____

_____

_____

**Major life activities assessment**

5. What area(s) of life activity is/are impacted by the above diagnos(is/es)? ***For receipt of reasonable accommodation(s), at least one area of substantial limitation must be present to meet the definition of disability under the ADAAA and FHA.*** Please use an X to indicate level of limitation for ALL life activities.

| Life Activity | No Limitation | Negligible Limitation | Moderate Limitation | Significant Limitation |
|---|---|---|---|---|
| Caring for one's self | | | | |
| Performing manual tasks | | | | |
| Seeing | | | | |
| Hearing | | | | |
| Eating | | | | |
| Sleeping | | | | |
| Walking | | | | |
| Standing | | | | |
| Lifting and/or bending | | | | |
| Speaking | | | | |
| Breathing | | | | |
| Learning | | | | |
| Reading | | | | |
| Concentrating | | | | |
| Thinking | | | | |
| Communicating | | | | |
| Managing internal distractions | | | | |
| Managing external distractions | | | | |
| Organization | | | | |
| Management of stressors | | | | |
| Interacting with others | | | | |
| Major bodily functions as listed below: | | | | |

6. What other specific symptoms are manifesting at this time that might affect the student's academic performance, residence life, and/or social functioning? *Please indicate N/A for not applicable.*

**Proposed reasonable accommodations**

7. What ***housing accommodations*** are recommended for this student?

What major life activities and/or bodily functions will be ameliorated through ***housing*** accommodation?

8. What ***academic accommodations*** are recommended for this student?

What major life activities and/or bodily functions will be ameliorated through ***academic*** accommodation?

9. What ***dietary accommodations*** are recommended for this student?

What major life activities and/or bodily functions will be ameliorated through ***dietary*** accommodation?

10. Please provide any additional recommendations or information that you believe would be helpful for the Disability Services Coordinator to know in their consideration of this request for reasonable accommodation:

_____

_____

_____

_____

_____

11. This student's disabilit(y/es) should be considered: ☐ acute ☐ chronic

12. Based on the above status and other diagnostic and treatment considerations, reevaluation of disability for the purpose of reasonable accommodation should occur after:

☐ 6 months ☐ 1 year ☐ 2 Years ☐ 3 years ☐ 4 years

**Acknowledgement**

I certify that my relationship with the student is as a healthcare provider in treatment of the mental and/or physical impairment(s) detailed above and that I have no other non-professional relationship with this student. I also verify that the information included on this form is current and accurate to the best of my knowledge based on my recent evaluation of this student and review of records.

Date (mm/dd/yyyy): _____

Healthcare Provider Name: _____

Specialty Area(s): _____

Professional Title & Credentials: _____

License Number: _____ Issuing State or Country: _____

***I confirm that my recommendations for the above named student is a medical necessity or specifically prescribed as part of a comprehensive treatment plan.***

Healthcare Provider Signature: _____

In the space below, please provide the following:

Organization/Clinic Name, Office Address, Phone, Fax, and Email (stamp or write below)