Earlham COLLEGE

Submit Form to:
Disability and Accessibility Services
801 National Road West
Richmond, IN 47374
TEL: 765 983-1390
FAX: 765 973-2120
odas@earlham.edu

Certification of Disability

The student named below is requesting services from Disability & Accessibility Services at Earlham College. The provision of reasonable accommodations for students with psychological 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 & Accessibility 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 processing the student's request with this form. **Please print legibly or type into document and complete in detail all sections of this form.**

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

Chosen Name: Pronouns:

Please provide us with the following **ONLY** if they have been diagnosed by you as a provider:

Primary Diagnosis: Date of dx:

☐Mild ☐ Moderate ☐ Severe

Secondary Diagnosis: Date of dx:

☐Mild ☐ Moderate ☐ Severe

Tertiary Diagnosis: Date of dx:

☐Mild ☐ Moderate ☐ Severe

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

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

   Date of most recent contact (mm/dd/yyyy):

Additional for Counseling Services providers:

Frequency of contact: ☐weekly ☐ 2x monthly ☐ quarterly ☐ other:

2. Please state the medication(s) or treatment plan/type of therapy currently prescribed:

3. What areas of functionality are impacted by the disability?

MEDICAL PROVIDERS ONLY : place check mark(s) on all that apply OR ☐ N/A_

Life Activity	No Limitation	Mild Limitation	Moderate Limitation	Severe Limitation
Caring for one's self				
Performing manual tasks				
Seeing				
Hearing				
Eating				
Sleeping				
Walking				
Standing				
Lifting or bending				
Speaking				
Learning				
Reading				
Concentrating				
Communicating				
Managing distractions				
Organization				
Management of stressors				
Interacting with others				

COUNSELING PROVIDERS ONLY: place check mark(s) below on all that apply OR ☐ N/A

Life Activity	No Limitation	Mild Impairment	Moderate Impairment	Severe Impairment
Communicating needs to others				
Managing internal distractions				
Management of emotions				
Distress tolerance skills				
Safety planning				

4. Are there any other contextual factors that should be considered at this time that may affect the student's academic performance, residence life, or social functioning? ☐ N/A

5. **Recommended *housing accommodations* for this student:** ☐ N/A

☐ Change in roommate ☐ Room Change ☐ Single Room ☐ Other: ____________________

How will the student's functional limitations as indicated in #3: Areas of functionality be relieved through this accommodation?

Will recommended housing accommodations be necessary for ensuring safety for self and others?
☐Yes ☐ No ☐ Unable to determine ☐ N/A

Will recommended housing accommodations be necessary to alleviate severe impairment(s) in psychological functioning?
☐Yes ☐ No ☐ Unable to determine ☐ N/A

6. **Recommended *academic accommodations* for this student?** ☐ N/A

☐Extended testing time ☐ Alternative testing location ☐ No evening exams
☐Noise cancelling ear plugs/headphones ☐ Reduced audience for oral exams/presentations
☐ Breaks during exams
☐ Other (indicate below)

How will the student's functional limitations as indicated in #3: Areas of functionality be relieved through this accommodation?

7. **This student's condition(s) should be considered (must select one):**

☐ Acute (6 months or less), reevaluation to occur within 1 year
☐ Chronic (greater than 6 months), reevaluation to occur within 3 years

Acknowledgment

I certify that my relationship with the student is professional. I am the healthcare or counseling provider in the treatment of the disability detailed above and I have no other non-professional relationship with this student. I also verify that the information included on this form is current and accurate based on my recent evaluation of this student and review of records.

Healthcare/Counselor Provider Name:

Specialty Area(s):

Professional Title & Credentials:

License Number: Issuing State or Country:

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

Healthcare/Counselor Provider Signature: ____

Date (mm/dd/yyyy):