Hartford International
UNIVERSITY FOR RELIGION & PEACE

Disability Accommodations Documentation

Office of Student Services, Hartford International University
77 Sherman St
Hartford, CT 06105
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Disability Documentation Form

This section to be completed by the student

Name:	
DOB:	
Address:	
Date:	

I freely and voluntarily authorize my physician or any other professional clinician who may share in my care to release any and all medical information to the Office of Student Services at Hartford International University for review and determination of reasonable and appropriate accommodations.

Patient Signature: _____ Date: _____

The student, whose name appears above, is in the process of requesting accommodations from the Office of Student Services at Hartford International University. In order to determine this student's eligibility for reasonable accommodations, we will need your assessment and diagnosis of this student's medical and/or psychological condition.

Americans with Disabilities Act Amendments Act (ADAAA) of 2008 and Americans with Disabilities Act of 1990 as revised in 2010 define a disability as a physical or psychological impairment that substantially limits one or more major life activities (i.e. learning, walking, talking, seeing, hearing, taking care of one's self). The provision of reasonable accommodations is based on an assessment of the current impact of the student's disability. As the manifestations of a disability may vary over time and in different settings, in most cases evaluations should have been conducted within the past year (i.e. low vision or neuromuscular conditions are often subject to change and should be updated for current functioning). Documentation should validate the need for services based on the individual's current level of functioning in an educational setting.

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***** This section to be completed and signed by Health Care Professional only *****

Please mail or email this completed form and any attachments to Office of Student Student Services

1. Patient/Client's Name: Currently under your care? ☐ **Y** ☐ **N**

2. When was the client/patient last seen?

3. Please provide a complete DSM-5 or ICD-10 code/diagnosis, diagnostic methodology, and description of the specific symptoms the student experiences.

4. The provision of reasonable accommodations is based on the current impact of the student's disability, therefore, please explain how the student's disability substantially limits one or more major life activities (i.e. learning, walking, talking, seeing, hearing, caring for self) within an educational setting?

5. How long has the patient had this condition?

6. Is there a current treatment plan? ◯ Yes ◯ No If yes, please describe:

7. Please list the prescribed medications and describe the effects on the student's ability to learn, concentrate, or pay attention, and any possible side effects of the medications.

8. Please describe any situations that may exacerbate the condition.

9. Suggested recommendations for effective and reasonable accommodations in an educational setting (i.e. extended testing time, preferential seating, etc.).

Required:	**Professional Provider Information**
Name (please print):	
Title and/or credentials:	
Area of Specialization:	
License Number:	
Address:	
Phone number:	
Email:	
Signature:	
Date:	

Your timely response is very important in order for this student to obtain necessary accommodation(s) at HIU