STUDENT DISABILITY SERVICES

Documentation of Disability

COMPLETED BY STUDENT

Student Name ______________________________ SSN ________________ DOB ____________

Date ____________________ UBTech Program ____

Address ________________________________ City, State ZIP ____________________________

Health Care Provider ____

I have submitted a request for a reasonable accommodation to my school under the Americans with Disabilities Act. The law allows my school to conduct an individual assessment of my condition before granting or denying a request for accommodation. Please **review your files and respond** to the listed questions to assist my school in undertaking that assessment. **Attach additional relevant written reports and test scores**. Thank you for your time and assistance.

COMPLETED BY HEALTH CARE PROVIDER

Qualifying professional must be an impartial individual who is not a family member of the student. He/she must be a medical doctor, licensed clinical social worker, or a licensed psychologist. He/she must be **qualified to diagnose under DSM/ICD guidelines** and have training and relevant expertise in the specific area of disability in which he/she is providing the diagnosis.

1. What is your **diagnosis** of my physical and/or mental health condition(s)? What tests or procedures were used to diagnose my condition? Please include interpretations of the results (lay terms please).

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2. **Comparing me to most people in the general population, please identify each major life activity or major bodily function** that is **substantially limited** by my health condition(s). Please indicate how and to what extent each major life activity is limited. Specify the **functional limitations**. (**Quantify where possible**, ie. How far? How long? How much?)

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3. Describe the **detrimental effects** of all the mitigating measures, e.g., medication, therapy, assistive devices, as they affect my participation in, or performance of the above identified **major life activities, compared to most people in the general population.**

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4. **Prognosis** Are my impairments and/or limitations **permanent, or will there be changes** over time? Please **describe any anticipated changes** and include the basis for your opinions.

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5. If my condition is episodic or in remission, please identify and detail the **nature, frequency, severity and duration** of anticipated future episodes. Please detail accommodations that may help me to perform the essential functions of my education.

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FREQUENCY _________ **Times per** _________ **Week** _________ **Month**
DURATION _________ **Hours or** _________ **days per episode**

6. How and to what extent does the disability limit my ability to perform learning tasks or functions required in a classroom/shop environment?

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7. Please provide your opinion concerning my ability to perform these essential functions, given your diagnosis and prognosis of my health condition(s). Please include the facts and pertinent health information that support your opinion.

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8. In your opinion, **what accommodations**, if any, will enable me to perform the essential functions of my education? Please indicate how your recommended accommodations will assist me in performing those essential functions.

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VERIFICATION

Diagnosed by ____ Report Date ____________

Address ___________________________________ City, State ZIP ___________________________

Phone ______________________________________ Fax ___________________________________

I, the undersigned, affirm that I have provided the information above and that said information is true and correct to the best of my knowledge and belief.

Signature ____ Date ________________________

Please send the requested information by fax (435-725-7199) or by mail to Jim LaMuth, ADA Coordinator, 450 North 2000 West, Vernal, Utah 84078