

**ACCESSIBILITY SERVICES
DOCUMENTATION OF DISABILITY FORM**

**TO BE COMPLETED BY THE DIAGNOSING
CLINICIAN**



(Please print)

Student's Name: _____ Today's Date: _____

Clinician's Name and Credentials: _____

Address: _____

Clinician's Phone Number: _____

Clinician's License/Cert. Number: _____

If you are related to this student, what is your relationship? _____

Clinician's Signature: _____

Disability Diagnoses (please fill out ALL Sections):

DSM/ICD code for Diagnosis #1: _____

Diagnosis (full diagnostic title): _____

Date of first diagnosis: _____

Duration: ☐ Permanent ☐ Chronic/Recurring ☐ Temporary (with end date): _____

DSM/ICD code for Diagnosis #2: _____

Diagnosis (full diagnostic title): _____

Date of first diagnosis: _____

Duration: ☐ Permanent ☐ Chronic/Recurring ☐ Temporary (with end date): _____

What evaluation methods/procedures/assessments were used to diagnose the condition(s)? Please attach available diagnostic reports, i.e. test results:

Functional Limitations (please fill out ALL sections):

Please list functional limitations/symptoms of the diagnosis the student is **currently** experiencing? _____

**ACCESSIBILITY SERVICES
DOCUMENTATION OF DISABILITY FORM**

**TO BE COMPLETED BY THE DIAGNOSING
CLINICIAN**



How might these symptoms limit the student's functioning in a post-secondary educational setting? _____

Medications currently being taken (including any adverse side effects which may impact the student): _____

Suggested Accommodations/Adjustments (please fill out ALL sections):

Academic accommodations/adjustments recommended: _____

Additional information that might be appropriate: _____

This form and/or any documentation may be forwarded to:

Mercy College of Ohio
Accessibility Services Office
2221 Madison Ave., Toledo, OH 43604
Fax: (419) 251-1746, Attn: AS Office
Email: ADA504@mercycollege.edu

Accessibility Services Office: (419)-251-1784

Thank you for your assistance!