



Guidelines for Providing Documentation of Physical and Mental Health Disabilities

These Guidelines may be used to document a disability, physical or mental health condition, including but not limited to:

- x Food Allergies
- x Chronic health conditions
- x Visual Impairments
- x Hearing Impairments
- x Mobility impairments
- x Anxiety
- x Depression
- x Bipolar disorder
- x Eating disorder
- x Posttraumatic stress disorder

The following guidelines are designed to provide students and professional diagnosticians with a common understanding of the components of documentation necessary to validate the existence of a disability, and accommodations that may be necessary for equal access in the postsecondary setting.

Documentation is required to provide adequate information that establishes the presence of a disability and the functional impact on major life activities along with justification of the need for requested accommodations. Documentation must be recent to accurately describe the current effects on the student. If documentation is inadequate in scope or content and does not support the presence of a disability and need for accommodations, Disability Services may require additional information.

The professional providing documentation for the student must be qualified to diagnose the disability and recommend appropriate accommodations. The name, title, and professional credentials of the provider, including information about license or certification, area of specialization, and state in which the individual practices, must be clearly stated in the documentation. It is not appropriate for professionals to provide documentation for members of their families. All submitted documents should be on letterhead, typed, dated, signed, and otherwise legitimate. Telephone calls, medical records, and brief letters are not sufficient.

A diagnosis alone will not necessarily establish disability status or warrant accommodations under state and federal laws. Accommodations must be necessary, reasonable, and appropriate. A clear link

It is strongly recommended that documentation include the following information for each individual student:

- 1) Presenting diagnosis, necessary and diagnostic categorization or classification of the ICD or DSM is preferred. Diagnosis should indicate primary, secondary, etc., and significant findings.
- 2) The examination/assessment/evaluation was performed for the presenting diagnosis, or if following a student for an extended time, date of the onset and an evaluation that is recent

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