



Medical and Mobility Disorders Documentation Instructions and Form

Updated August 2026

Student Instructions and Information:

- Students must submit **current** documentation to the Office of Accessibility and Testing Services.
 - Current documentation is defined as:
 - Documentation that reflects data collected within three years at the time of request for services UNLESS the condition is of a permanent and non-varying nature. If additional accommodations are requested due to changes in functional limitations, updated documentation may be requested.
 - It is at the Accessibility and Testing specialist's discretion to make appropriate exceptions to this policy and/or to request a reevaluation and more recent documentation in order to establish the most appropriate accommodations.
- A qualified provider (medical doctor) must provide the documentation.
- In place of this form, a letter may be provided including all of the requested information. Any letters must be on letterhead from the provider's practice. Any documentation must include the provider's signature and credentials.
- Students are asked to provide documentation **prior to the intake meeting** if at all possible. It is during the intake meeting that appropriate accommodations, and the process for using the accommodations, will be discussed.
- For timely review of application, documentation must be submitted by the student requesting services via our [Accommodations Request Application Portal](#), located on our website. If you have any questions regarding this process, please email to accessibility-services@westga.edu.

To be Completed by Student:

Name (Last, First, Middle): _____

Date of Birth: _____ UWG ID Number: 917 _____

Cell Phone: _____ Alternate Phone: _____

Home Address: _____

Email Address: _____

Status (Check One): ☐ Current Student ☐ Transfer Student ☐ Prospective Student

To be Completed by Provider:

The Office of Accessibility and Testing Services establishes academic and/or housing accommodations for students with a documented disability. The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities. The University System of Georgia Board of Regents (USGBOR) requires current and comprehensive documentation for any diagnosis of a disability in order for disability services providers to determine appropriate accommodations and services. Please see [Appendices D-H of the USGBOR Academic and Student Affairs Handbook](#) for more information.

Primary Diagnosis: _____

DSM-5/ICD-10 Code: _____ Date of Diagnosis: _____

Secondary Diagnosis: _____

DSM-5/ICD-10 Code: _____ Date of Diagnosis: _____

Please provide the diagnostic criteria and methodology used to diagnose the condition.

Please describe the history and severity of the disorder.

Is it expected that the patient's functioning and/or severity of the disorder will change over time?

_____ Yes _____ No

If yes, please explain the anticipated progression.

Please check all of the following as appropriate to describe the patient's functional limitations.

- ☐ Use of a wheelchair or scooter to aid mobility
- ☐ Limited stamina
- ☐ Fatigue
- ☐ Headaches accompanied by nausea, vomiting, and/or sensitivity to light and sound
- ☐ Limited upper body mobility, trouble grasping, handling objects
- ☐ Lack of muscle control and balance
- ☐ Poor coordination
- ☐ Limited ability or unable to write/keyboard
- ☐ Affected speech
- ☐ Bowel and/or bladder incontinence
- ☐ Pain
- ☐ Low tolerance for temperature changes/extremes
- ☐ Problems being exposed to fumes/dust/mold/gasses, etc.
- ☐ Trouble with focus and concentration
- ☐ Breathing difficulties
- ☐ Problems with depression or mood swings
- ☐ Difficulty reading
- ☐ Limited space, form, and/or depth perception
- ☐ Field of vision deficit
- ☐ Medication side effects

Other ☐

Other ☐

Other ☐

Please provide any additional information/context as appropriate concerning the functional limitations.

Please provide any recommendations to address the indicated functional limitations.

Please attach any psychological and/or educational reports that support the diagnosis and associated functional impact and complete the following information:

Provider Name: _____

Title: _____

License #: _____

Practice Name and Address: _____

Phone: _____ Fax: _____

Email: _____

Provider Signature **(REQUIRED)**: _____

Date of Signature: _____