Medical and Mobility (Systemic/Visual) Disorders Documentation Instructions and Form
Updated March 2024

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 [secure portal, AIM](#) 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: _________________________________________