



## Medical and Mobility (Systemic/Visual) Disorders Documentation Instructions and Form

Updated January 2023

### Student Instructions and Information:

- Students must submit **current** documentation to Accessibility 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 Services counselor'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.
- Documentation can be submitted in person or by mail to the UWG Accessibility Services, 123 Row Hall, Carrollton, GA 30118, by fax to 678-839-6429, or by email to [accessibility-services@westga.edu](mailto: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 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.

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Please describe the history and severity of the disorder.

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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.

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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

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Other ☐ 

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Other ☐ 

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Other ☐ 

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

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Please provide any recommendations to address the indicated functional limitations.

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**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: \_\_\_\_\_

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Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Provider Signature **(REQUIRED)**: \_\_\_\_\_

Date of Signature: \_\_\_\_\_