

Disability Support Services

Lesley University
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<u>For Office Use Only</u>
Date Received:

**Chronic or Degenerative Disability
Disclosure Form**

The licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document **must** complete this form.

INCOMPLETE FORMS WILL DELAY POTENTIAL SERVICES

Student's Name: _____ Date: _____

Clinician's Name: _____

State Licensure/ Certification #: _____

Area of Specialty: _____ Clinician's phone #: _____

Address:

The person named on this form is requesting accommodations from Disability Support Services, which offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act Amendments Act (ADAAA) revised in 2008. Under the ADAAA guidelines a person with a disability is one with a physical, mental, emotional or chronic health impairment that **substantially limits** one or more major life activity such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

- **I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADAAA disability criteria: Yes No**

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disorder.

1. Description of the chronic or degenerative disorder or primary disability:

2. The extent of the disorder is: Mild Moderate Severe

3. Date of Onset:

4. Date of last clinical contact:

5. Expected duration of medical disorder or disability noted above is:

- Permanent/ Chronic
- Long term: 3-12 months

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6. What is the frequency and duration of symptoms of the student's condition?

- Daily 1/week 1-3/week 1/month 1-3/year Seasonal
- None – symptoms under control with medication Other:

7. **Assessment Instruments and Results:** (Please describe the procedures used to establish the condition):

8. Medications:

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

9. History of hospitalization:

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10. Describe the functional impact of symptoms in the academic setting:

11. Is this student aware of any realistic limitations regarding how the chronic or degenerative disorder may impact their academic performance?

12. Suggested accommodations:

13. Additional information:

Clinician Signature: _____ Date: _____