WISCONSIN LUTHERAN COLLEGE
ACCESSIBILITY SERVICES

Provider Documentation Form

This documentation form is provided by the Office of Accessibility Services to assist students in submitting the appropriate medical or mental health information for the purposes of requesting accommodations or modifications to policy/procedure that will allow for greater access to our academic and campus-life programs. This form must be completed by a medical or mental health care provider licensed to make the diagnosis(es) listed, and who has a detailed understanding of how it may affect the student in the college environment.

After the completed form is submitted, Accessibility Services staff will engage in an interactive process with the student to determine the appropriateness of the accommodation(s) requested. **The final decision regarding appropriate accommodation(s) will be determined by Accessibility Services staff.** There may be situations in which staff will need to contact the professional who completes this form for additional clarification.

The information provided in this form is not part of the student's educational records and will be kept in a confidential file in the Office of Accessibility Services. If you have any questions regarding this documentation form, please call 414-443-8797.

STUDENT INFORMATION

Name: _____ Warrior ID: _____
Email Address: _____ Phone Number: _____

PROVIDER INFORMATION

Name: _____ Title/License: _____
Clinic/Organization: _____ Phone Number: _____
Address: _____ City:_____ State: _____ Zip:_____

Did you make the initial diagnosis/es of the conditions(s) being documented in this form?

☐ Yes – Answer questions below

- How did you arrive at the diagnosis? Check all that apply
  - ☐ Interview with Student
  - ☐ Interview with Others (parent, teacher)
  - ☐ Behavioral Observations
  - ☐ Consideration of developmental and/or medical history
  - ☐ Rating Scales
  - ☐ Neuro/psychoeducational testing
  - ☐ Other: _____

☐ No – Answer questions below

- Can you affirm that the student continues to meet the diagnostic criteria of the condition? ☐ Yes ☐ No
- Contact information for the person who made the diagnosis
  Name: _____ Title/License: _____
  Phone Number: _____ Organization/Clinic: _____

Do you have an ongoing treatment relationship with the student?

☐ Yes – Date of the last appointment/interaction: _____

☐ No

Comments:

DISABILITY INFORMATION

Use this section to document diagnosed medical or mental health conditions that may affect the student's ability to access academic and/or campus-life programs. Please avoid speculative language and only include diagnoses you are licensed to make/confirm. Other providers may be asked to submit documentation of other conditions.

Diagnosis	Status		Symptoms	
	☐ Chronic ☐ Temporary	☐ Stable ☐ Unstable	☐ Daily ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe
	☐ Chronic ☐ Temporary	☐ Stable ☐ Unstable	☐ Daily ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe
	☐ Chronic ☐ Temporary	☐ Stable ☐ Unstable	☐ Daily ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe
	☐ Chronic ☐ Temporary	☐ Stable ☐ Unstable	☐ Daily ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe
	☐ Chronic ☐ Temporary	☐ Stable ☐ Unstable	☐ Daily ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe

LIFE ACTIVITIES ASSESSMENT

Describe the nature of the disability and any functional limitations created by it.

A disability is defined as a medical or mental health condition that substantially limits one or more major life activities. A "substantial limitation" creates a significant restriction in the condition, manner, or duration in which a major life activity is performed or compared to most people. Some diagnosed conditions will not meet that definition.

Please indicate the impact of the student's disability on each of the following.

Life Activity	Mild	Moderate	Substantial	N/A	Comments
Operation of a major body function					
Mobility					
Sight					
Hearing					
Speaking					
Reading (comprehension/ fluency/ speed)					
Writing (expression/ fine motor skills)					
Auditory Processing					
Mental Processing					
Focus / Concentration					
Communication					
Interactions with others					
Activities of daily living					

Time Management					
Organizational Skills					
Task Persistence					
Memory Skills					
Concentration					
Self-esteem					
Social Skills					
Attending Class					
Stress Management					
Eating					
Sleeping					

ACADEMIC EFFECTS

How does this condition/impairment impact the student's ability to participate and learn in an academic setting?
If this condition/impairment does not affect the student academically, please indicate with an "N/A".

SUGGESTED ACOMMODATIONS

What, if any, accommodations do you suggest Accessibility Services should consider, ensuring equal access and opportunity to participate in college academics and campus life. Include a brief rationale indicating how it addresses a specific disability-related need of the student.

**These are suggested accommodations and final determination will be made by Accessibility Services as some may not be reasonable/appropriate for the student's program of study.*

- ☐ Reduced distraction testing environment
- ☐ Extended time on tests
- ☐ Notetaking support (i.e. peer support, lecture recording)
- ☐ Alternative textbooks
- ☐ Preferential seating
- ☐ Assistive technology (i.e. screen reader, voice-to-text)
- ☐ Disability Parking
- ☐ Housing Preference
- ☐ Priority Registration
- ☐ Other: _____
- ☐ Other: _____

Rationale:

ONGOING TREATMENT & CARE PLAN

Indicate the current treatment plan for the previously mentioned diagnosis(es) including any pharmaceutical support that may affect the student academically, socially, etc.

Do you recommend any additional assessment for the student? If so, please indicate below.

- ☐ Psychological Testing
- ☐ Learning Disabilities
- ☐ Medical Conditions
- ☐ Sleep Study
- ☐ Other: _____

In your professional opinion, does this student's diagnosis(es) impact them to the level of meeting the criteria of a disability?

ADA defines a person with a disability is someone who has a physical or mental impairment that substantially limits one or more major life activities, has a history or record of such an impairment or is perceived by others as having such an impairment.

- ☐ Yes
- ☐ No

Is there anything else we should know about the student as it relates to their request for accommodations through Accessibility Services? (attach additional pages as needed)

PROVIDER SIGNATURE

By signing this form, you affirm that you, the treating/assessing professional, have completed the form and have followed the ethical guidelines of your scope of practice.

Signature: _____ Date: _____

Name: _____ License #: _____

PLEASE ATTACH ANY DIAGNOSITC REPORTS, PSYCHOEDUCATIONAL ASSESSMENTS, OR NEUROPSYCHOLOGICAL EVALUATIONS ASSOCIATED WITH THIS CASE.