

**Disability Documentation Form**

This documentation form is provided by Marquette University’s Office of Disability Services to assist students in submitting 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, if used, should be completed by a medical or mental-health care provider licensed to make the diagnosis/es listed on the form, and who has a detailed understanding of how the student may be affected by their diagnosis at a university. After an appropriately completed form is submitted, Marquette University staff will engage in an interactive process with the student to determine the appropriateness of the accommodations requested. There may be situations in which staff will need to contact the professional completing this form for clarification.

If you have any questions when completing this documentation form, please call the Office of Disability Services at 414-288-1645.

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| Name of Student: |  | Birth Date: |  |
|  | MU ID (if known): |  |  |

1. Did you make the initial diagnosis/es of the condition(s) being documented with this form? [ ]  Yes [ ]  No
	1. If no, can you affirm that the student continues to meet the diagnosis criteria of the condition? [ ]  Yes [ ]  No
2. Do you have an ongoing treatment relationship with the student? [ ]  Yes [ ]  No
	1. When did you last interact with this student?

|  |  |
| --- | --- |
| Date:  |  |

Please use this section to document diagnosed medical or mental health conditions that may be affecting the student’s access at our institution. Please avoid speculative language, and only include diagnoses that you are licensed to make/confirm. Other providers may be asked to submit documentation of other conditions.

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| Diagnosis |  |
|  | [ ]  Long-Term Disability [ ]  Temp. Impairment, Expected Duration: \_\_\_\_\_\_\_\_\_\_\_\_  |
|  | [ ]  Long-Term Disability[ ]  Temp. Impairment, Expected Duration: \_\_\_\_\_\_\_\_\_\_\_\_  |
|  | [ ]  Long-Term Disability[ ]  Temp. Impairment, Expected Duration: \_\_\_\_\_\_\_\_\_\_\_\_  |
|  | [ ]  Long-Term Disability [ ]  Temp. Impairment, Expected Duration: \_\_\_\_\_\_\_\_\_\_\_\_  |
|  | [ ]  Long-Term Disability [ ]  Temp. Impairment, Expected Duration: \_\_\_\_\_\_\_\_\_\_\_\_  |

**Major Life Activities Assessment**

A “disability” is a mental health or medical 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 compared to most people. Some diagnosed conditions will not meet that definition.

1. **Please consider whether the student is substantially limited, and if so, describe how the student is substantially limited in one or more major life activities:**

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**Academic Effects**

1. 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 progress to section II.

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* 1. If the student is currently undergoing medical treatment (including the use of medication) which would affect the student academically, please describe that below.

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* 1. If you feel comfortable doing so, you may suggest accommodations for us to consider with the student. It is helpful to discuss these with them before noting them here. *If suggesting an accommodation, it must be accompanied with a justification or a description of how it addresses a specific disability-related need that a student would experience at a university. Some suggested accommodations may not be appropriate for a student’s program of study.*

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**Housing Effects**

1. Does this condition/impairment require housing accommodations? If so, please describe the current functional limitation or effects of the disability, in the housing environment.

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* 1. If the student is currently undergoing medical treatment, please describe and indicate how this treatment might impact their living environment (i.e. medical devices, medication management etc).

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* 1. If housing modifications are needed, and you feel comfortable doing so, you may suggest accommodations for us to consider with the student. It is helpful to discuss these with them before noting them here. *If suggesting an accommodation, it must be accompanied with a justification or a description of how it addresses a specific disability-related need.*

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1. Campus life is varied; are there other aspects of campus life that may be affected by the disabilities documented on this form? If so, please describe them here.

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1. Is there anything else you would like us to know about this student?

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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.

Please sign, date and return to our office.

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| --- | --- | --- | --- | --- |
| Signature: |  |  | Date: |  |
| Name: |  |  | License #:  |  |
| Address: |  |  | Telephone #: |  |
|  |  |  | Fax #:  |  |