# Request for Documentation of a Disability

**Disability Accommodations & Support Services**
**Arroyo Hall 210**
**Telephone 805-437-3331 Fax 805-437-8529 Email: accommodations@csuci.edu**

The student named below has requested accommodations through Disability Accommodations & Support Services (DASS) at Cal State Channel Islands. In order to provide reasonable accommodations, we require documentation of the specific functional limitations that result from the individual's disability and/or medication side effects. General statements about the disability or medication do not help determine appropriate accommodations. The purpose of the functional limitations is to indicate how a specific disability or medication side effects substantially interferes with a major life activity, such as working or learning.

*Information on this form will be used in confidence for the educational benefit of the student.*
*This information will be released to other parties only with the express written request of the student.*

**Please complete this form, or ON YOUR OFFICE'S OFFICIAL LETTERHEAD, please respond in detail to each question and include your name, license number, phone, fax, address, signature, and date.** Thank you for your assistance. If you have further questions, please contact DASS at 310-437-3331 or accommodations@csuci.edu.

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First Name Middle Initial Last Name Date of Birth

**1) DSM-5 and/or ICD-10 Diagnosis(es)**

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Diagnosis Specification Code Date of Diagnosis

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Diagnosis Specification Code Date of Diagnosis

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Diagnosis Specification Code Date of Diagnosis

Details:

_____

_____

**2)** What historical data was taken into account in making the diagnosis?

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**3)** What were the assessment or evaluation procedures used to make this diagnosis?

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4) Please indicate the major symptoms of the disability currently manifested by the student, including level of severity *(mild, moderate, or severe*).

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5) What medications are currently prescribed?

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6) How long has the patient been under your care and is the individual currently in treatment with you? When did you last see him or her?

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**7)** What are the current functional limitations imposed by the disability or medication side effects? (e.g. difficulty: switching modalities, managing time or deadlines, formulating or executing a plan of action, taking notes, focusing during timed tests, tolerating interruptions, focusing for extended class period; easily distractible/poor concentration; panicking in crowded conditions/surroundings; unable to share a space in close proximity with someone; unable to ingest gluten, etc.) ***Please note that accommodations will be determined based on documented, specific functional limitations.***

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***Certifying Professional:***

*Diagnoses must be within the professional expertise and scope of practice of the certifying professional.*

_____

Clinician's Printed Name | Clinician's Signed Name | Date | License #

_____

Title | Phone | Fax

_____

Street Address | City | State | Zip