



## 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.

First Name

Middle Initial

Last Name

Date of Birth

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

Diagnosis

Specification

Code

Date of Diagnosis

Diagnosis

Specification

Code

Date of Diagnosis

Diagnosis

Specification

Code

Date of Diagnosis

Details:

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

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

- 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.*

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Clinician's Printed Name	Clinician's Signed Name	Date	License #
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Title	Phone	Fax	
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Street Address	City	State	Zip
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