SOUTH DAKOTA STATE UNIVERSITY

Office of Disability Services

Disability Assessment Form

(Please complete both pages of form)

To Whom It May Concern:

South Dakota State University provides academic services and accommodations for students with disabilities. Students are required to provide documentation that verifies that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for academic accommodations is based on documentation that clearly demonstrates a student has one or more functional limitations in an academic setting, and that one or more accommodations is needed to achieve equal access.

Legal protection and eligibility for such services is based on a student providing sufficient information to conclude that he/she has an impairment that **substantially limits** one or more major life activity. As this student's treating specialist, you are asked to provide the following information to allow SDSU to consider this student's request(s).

Please complete the following:

1. **Student Information**
    a. Patient/Client Name
    b. Preferred Name:
    c. Date of Birth (mm/dd/yyyy):
2. **The Condition of Patient/Client:**
    a. What is the diagnosis/impairment? (DSM-V or ICD-10-CM, if relevant)
    b. Date of diagnosis:
    c. Date of first contact with the patient/client:
    d. When did you last see the patient/client?
    e. Is the patient/client currently under your care?
    f. Is the impairment temporary (<3 months) or persistent?
    g. Please identify any factors that may affect the severity of the impairment (e.g., to what degree might the impairment be *minimized* by medications, hearing aids, etc.?) Alternatively, could there be an adverse effect (e.g., medication side effects)?

3. **Functional Impact Assessment (Required):**

Please rate the frequency/duration and severity using "x") of the condition's impact on major daily life activities to the best of your knowledge. For comparison purposes, please use same age peers in a postsecondary setting.

Major Life Activity	**Frequency/Duration (0-4 Scale) 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic**	**Severity**			
		Unknown/ N/A	**Mild**	**Moderate**	**Severe**
Caring for Oneself					
Talking					
Hearing					
Breathing					
Seeing – Close Distance					
Seeing – Long Distance					
Lifting/Carrying					
Performing Manual Tasks					
Eating					
Sleeping					
Standing/Walking					
Learning					
• Reading					
• Writing					
• Spelling					
• Calculating					
• Concentrating					
• Memorizing					
• Listening					
• Speaking					
• Other:					

4. **What method(s) were utilized to assess functional limitation? Please list or attach under separate cover.**
    a. Behavioral Observations
    b. Developmental History
    c. Medical History
    d. Structured or Unstructured Clinical Interviews with the Student
    e. Neuropsychological or Psychoeducational Testing
        i. Dates of Testing _____
    f. Other (please specify) _____

(*Please attach/fax diagnostic report of assessment – Fax: 605-688-4987)*

5. **List current symptoms/problems, functional limitations. Describe differential diagnoses that were ruled out.**

6. **List your recommendations for accommodations within the postsecondary environment. Provide a rationale for any recommendation made utilizing data from objective measures, educational record, or other data sources. For housing accommodations, include a clear description of the desired housing configuration and the consequences of not receiving the request. Please list or attach under separate cover.**

7. Certifier Information

a. Clinician Name *(print)* _____

b. Clinician Name *(signature)* _____

c. Medical Specialty_____ License # _____

d. Clinic/Facility Name _____

e. Address _____

f. Phone _____ Email _____ Date _____

Please send completed form and any additional information to South Dakota State University Office of Disability Services

Mail: 1421 Student Union Lane SSU 271 Box 2815
Brookings, SD 57007
Phone: (605) 688-4504
Fax: (605) 688-4987
Email: SDSU.DisabilityServices@sdstate.edu

If you have any questions, please feel free to contact our office. Thank you.