

NOTE:

This form can NOT be used for

ADD/ADHD

or

Psychiatric Disorders

(Depression, Bi-Polar, Anxiety Disorder, etc.)

or

Learning Disabilities

*****Please be aware that additional
documentation may be required by
Disability Services*****

For more information on documentation
requirements and guidelines for the above
disorders and others visit
<http://www.utsa.edu/disability>.

The University of Texas at San Antonio

**Disability Documentation Form
for Students with Mobility Impairments
and Other Functional Limitations due to Medical Conditions**

Date: _____

Name of Student: _____

Dear Medical Professional:

The student whose name appears above has applied for disability services/accommodations at Disability Services (DS) at the University of Texas at San Antonio (UTSA). In order for the DS to establish whether this student has a disability and to determine his/her eligibility for services, we will need your clinical assessment/diagnosis of this student. A disability is defined as a **physical or mental impairment that substantially limits** one or more major life activities such as those delineated below. You can fax or mail this form to DS using the contact information listed above. Thank you for your time and assistance in this matter.

1. Is the patient/student currently under your care? If yes, for how long?

2. What is the diagnosis/impairment/condition? (Please describe and use ICD 10 diagnostic codes)

3. Date diagnosis was made:

4. When did you last see the patient/student?

5. Major Life Activities Assessment: (Note: If testing was completed to diagnose the condition, please attach any supporting information, e.g., neurological or psycho-educational test reports, etc.)

Please check which of the **major life activities** listed below are affected in a learning environment because of the impairment/condition and please indicate the level of limitation.

Life Activity	1 - Negligible	2 - Moderate	3 - Substantial
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing as it relates to the medical condition you are treating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing as it relates to the medical condition you are treating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing as it relates to the medical condition you are treating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping as it relates to the medical condition you are treating (e.g. due to seizure activity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating as it relates to the medical condition you are treating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memorizing as it relates to the medical condition you are treating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading as it relates to the medical condition you are treating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for Oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. What are the **specific functional limitations** resulting from the impairment's impact on the major life activities in a learning environment identified above (e.g., unable to attend classes due to side effects from condition or medication; difficulty ambulating distances between classes; unable to keyboard more than 10 minutes out of 60 minutes)?

7. Are the functional limitations permanent? If not, anticipated date of resolution? Prognosis?

8. List any medications and described effects and possible side-effects on the medical condition you are treating:

9. If student is currently undergoing treatment (e.g. chemo therapy) please describe the treatment and how this treatment may affect the student in a post-secondary setting.

Note: Tests of cognition, information processing and academic achievement, which may not be part of the diagnostic process itself, may be needed by DS to determine appropriate academic accommodations and services for a student with a mobility impairment or other impairment due to a medical condition.

Signature of Medical Professional

Date

Medical Professional's Name (printed)

License No.

Address

Telephone No.

Fax No.

University of Texas at San Antonio
Student Disability Services
One UTSA Circle, MS 3.01.16 San Antonio, Texas 78249-0690
210-458-4157 (Voice)
210-591-7318 (Videophone)