A disability is defined under the Americans with Disabilities Act as “A physical or mental impairment that substantially limits one or more major life activities.”

A student with a physical or health related disability that is requesting accommodation(s) is required to provide documentation from an appropriate licensed healthcare professional to support academic and/or non-academic accommodation. The student requesting disability accommodation must submit this form that has been completed and signed by their healthcare provider with a demonstrated area of specialization in the diagnosis and treatment of the disease diagnosed.

I. Student: To be completed by student

Name: Last____________________________First__________________M________________
Date of Birth: _____ / ____ / ________ Student ID # ________________________________
FR / SOPH / JR / SR (CIRCLE If Known)

II. Medical Condition Information: To be completed by Healthcare Professional

1. Type of physical or medical condition requiring accommodation: *if the diagnosis is ADD/ADHD, then the ADD/ADHD/Psychiatric/Neurological Form needs to be completed.

   ICD 10 code(s) ______________________________________________________________

2. Date of original diagnosis: ___________ Date of last evaluation for this diagnosis: ___________

3. Diagnostic testing used to support the diagnosis and requested accommodation/dates performed:

   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________

4. Current and past treatment: _______________________________________________

   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________

   Current and past accommodations: _______________________________________________

   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________
III. Statement of Disability

1. In your opinion, does the student’s medical condition(s) **substantially limit a major life activity** and thereby rise to the level of disability?  ___ Yes  ___ No

2. Describe functional limitations that may warrant academic and/or non-academic accommodations: *(assess degree of each limitation as mild, moderate, severe)*

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

3. Describe accommodations requested: *(specify how the accommodation is related to the medical diagnosis)*

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. Duration of accommodation(s):
   - Temporary/short termed ___ Yes  ___ No  End date *(if yes) ___ / ___ / _______
   - Long termed ___ Yes  ___ No  End date *(if yes) ___ / ___ / _______

5. Other comments / recommendations:  __________________________________________
                                           __________________________________________
                                           __________________________________________

IV. Licensed Healthcare Provider

Name (Print): ___________________________ License #: ___________________________
Address:  ________________________________________________________________
Office Phone #: ___________________________ Fax #: ___________________________
                                           __________________________________________  ___ / ___ / _______
Signature                                  Date

Submit to:
Gettysburg College Office of Academic Advising
300 North Washington Street
Campus Box 414
Gettysburg, PA.  17325
Office: 717-337-6579  Fax: 717-337-6245
Documentation of physical & health disability form / 06/2015 / sreynolds CRNP