Southeast Arkansas College Office of Disability Services
Medical Disability Documentation Request Form

TODAY’S DATE: ___________________________________________________________
STUDENT’S NAME: _______________________________________________________
HOME ADDRESS: _______________________________________________________
TELEPHONE: ___________________________________________________________

The Southeast Arkansas College student named above is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations due to his/her physical or systemic impairment from the Office of Disability Services (ODS). In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, College Policy requires that a qualified professional provide current and comprehensive documentation. A qualified professional includes a medical doctor or other qualified healthcare professional who is not a family member of the student. In order to be considered current, the qualified professional’s statement must be within 6 months prior to the date of the most recent request from ODS.

The documentation provided must include information that diagnoses a physical or systemic (medical) disability, describes the functional limitations in an educational setting, indicates the severity and longevity of the physical or systemic (medical) disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication along with any current side-effects which may impact academic performance.

If it is a visual disability, the documentation must include the student’s visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged text is recommended as an accommodation.

Under the Americans with Disabilities Act and the Rehabilitation Act of 1973, an individual with a disability means any person who:

1. Has a physical or mental impairment which substantially limits one or more major life activities;
2. Has a record of such an impairment; or
3. Is regarded as having such impairment, whether he/she has the impairment or not.

“Major life activities” include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, and working, as well as mental and emotional processes such as thinking, concentrating, and interacting with others.
Please provide the following information:

Diagnosis (as diagnosed by the DSM-IV):

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Date of Diagnosis: _____________ Date of Last Contact with Student: ______________

Prognosis:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Describe the student’s functional limitations or restrictions in an educational setting, if any:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Expected date restrictions will be lifted, if any:
_________________________________________________________________________

Describe clinical evidence of disability, i.e. physical findings, x-rays, lab tests:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Please indicate the recommendations you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student’s educational opportunities at SEARK College as justified based on the functional limitations indicated above.
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Qualified Professional's Signature:
_________________________________________________________________________

Printed Name & Title:
_________________________________________________________________________

Daytime Telephone Number: _________________________________________________

Address: _________________________________________________________________

Date: ____________________________________________________________________
Return this information marked confidential to:

Office of Disability Services
Counselor
SEARK College
1900 Hazel Street
Pine Bluff, Arkansas 71603

Notes: It may be necessary to re-submit documentation for conditions not of a chronic nature. Our policy regarding documentation prohibits the dissemination of documentation to you or anyone requesting it once it is received. Therefore, once this form is submitted, we will be unable to disseminate copies to anyone.