THE CATHOLIC UNIVERSITY OF AMERICA

Disability Form To Be Completed by Clinical Professional

(to be completed by treating clinician)

Today's Date: ________________________

Student's Name:____________________________________ **Student's ID:** ________________

1. Diagnosi(e)s:

____

____

2. How did you arrive at your diagnosis? Please check all relevant items below; adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student:

Structured or Unstructured interviews □ Medical tests □

Interviews with other persons □ Medical History □

Behavioral Observations □ Developmental History □

3. Date of Diagnosis: ____

4. Date student was last seen: _____________________________

5. How long have you treated this student? ____

6. How often is the student required to check-in with a physician?

Once a week Once a month Every three-four months Every six months

Once a year As needed Other:_____________________

Office of Disability Support Services

620 Michigan Ave., N.E. | Washington, DC 20064 | 202-319-5211 | 202-319-5126 (FAX) |
cua-dss@cua.edu | dss.catholic.edu |

THE CATHOLIC UNIVERSITY OF AMERICA

7. Is the student currently taking medication(s) for this issue? YES NO

If yes, what medications is the student currently taking? For each medication, describe the side effects and any impact on academic performance.

Medication	**Side Effects**	**Academic Impact**

8. Please check which areas listed below the student is functionally limited in because of the medical diagnosis and/or the medication. Please indicate the level of limitation.

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	**2**	**3**	**4**	**5**	**Major Life Activities**		**1**	**2**	**3**	**4**	**5**	**Learning/ Time Management**
					Caring for self							Memory
					Talking							Concentrating
					Hearing							Listening
					Breathing							Organization
					Seeing							Managing distractions
					Walking							Timely submission of assignments
					Standing							Attending class regularly
					Lifting/Carrying							Making and keeping appointments
					Sitting							Managing stress
					Performing Manual Tasks							Reading
					Eating							Writing
					Working							Spelling
					Interacting with others							Math
					Sleeping							Processing Speed

THE CATHOLIC UNIVERSITY OF AMERICA

9. What other specific symptoms manifesting themselves at this time might affect the student's academic performance?

____

____

10. Have there been any changes in the student's condition in the past 12 months? NO YES
Please explain.

____

____

11. Do you anticipate any changes in the student's condition in the next 12 months? NO YES
Please explain.

____

____

12. Is there anything else you think we should know about the student's medical condition?

____

____

____

PLEASE TYPE OR PRINT CLEARLY

Name & Title ____

Signature______________________________ **Date:** ______________

License/Certification #____________________ **State** ______________

Address ____

City, State, Zip Code____

Phone ______________________ Updated 7/2019