Documentation for Accommodation Needs Form

The purpose of this form is to provide Central Connecticut State University’s Student Disability Services with documentation of medical, psychological condition, and/or disability for academic, housing, and/or parking accommodations.

Instructions:

1. The student should complete the Student Information section on page 2.

2. The student, or their parent/legal guardian if under the age of eighteen (18), should fill out and sign the Authorization to Release Health Care Information on page 3. This signature gives the health care provider permission to complete the information requested on this form and to speak with a specialist at Student Disability Services.

3. The student should ask a treating and licensed clinical professional or health care provider to complete the Medical/Health Care Provider Documentation section on pages 4 – 7. The professional/provider must be thoroughly familiar with the student’s physical or psychological condition(s) and resulting functional limitations and/or restrictions. Further, the professional/provider may not be related to the student through blood, marriage, or other legal arrangement.

4. This completed form should be submitted to the CCSU Student Disability Service office.

Mail:  
Student Disability Services  
Willard Hall Room 101-03  
1615 Stanley St.  
PO Box 4010  
New Britain, CT 06050-4010

Fax:  
Fax this document to 860.832.1865 Attention: Student Disability Services Coordinator

Email:  Scan and email to DisabilityServices@ccsu.edu
**Student Information**

*Student completes the section below.*

Student’s Name: ________________________________________

Last               Middle               First

Address: ________________________________________________

Street Address     Apartment/Unit #

City               State               Zip Code

Phone: ______________________   Email: ________________________________

Student ID: ______________

Student status:
☐ Current CCSU student   ☐ Incoming new/transfer student

Class standing:
☐ Incoming new student   ☐ Sophomore (26-53 credits)   ☐ Senior (86+ credits)
☐ First-year (0-25 credits)   ☐ Junior (54-85 credits)   ☐ Graduate Student

Type of accommodations being requested (check all that apply):
☐ Academic   ☐ Housing   ☐ Parking

Term accommodation is requested to begin:
☐ Fall   ☐ Winter   ☐ Spring   ☐ Summer
Authorization to Release Health Care Information

*Student or parent/legal guardian completes the section below.*

I authorize the provider listed below to release information and medical records related to my request to Central Connecticut State University’s Student Disability Services for the purpose of determining and obtaining appropriate academic/housing/other accommodations. I understand Central Connecticut State University’s Student Disability Services may review this documentation and may contact me for further information and/or to discuss options related to my request(s). Furthermore, I give my consent for a specialist from Central Connecticut State University’s Student Disability Services to contact the professional completing this form for additional information as needed.

Name of Provider: ______________________________________________________________

Specialty: ____________________________________________

Address: ______________________________________________________________________

Street Address

City State Zip Code

I have read and understand the above information.

________________________
Printed Name of Student

________________________
Signature of Student or Legal Representative Date

Printed name of Legal Representative Relationship to student

Office of Student Disability Services
Equal Opportunity Employer and Educator
Medical/Health Care Provider Documentation

*Medical/health care provider completes the section below.*

Student’s Name: ____________________________________________________________________

To determine eligibility for accommodations because of a disability/chronic health condition, Central Connecticut State University requires current and comprehensive documentation of the student’s medical condition and medical records from the treating and licensed clinical professional or health care provider thoroughly familiar with this student’s condition and his/her functional limitations and/or restrictions. Items 1 through 11 must be completed in full. If the spaces provided are not adequate, please attach a separate sheet of paper.

Please respond to the following items regarding the student named above:

1. Please provide a complete medical or DSM-IV-TR or DSM-5 diagnosis.

   _______________________________________________________________________________

2. When was this condition diagnosed?

   _______________________________________________________________________________

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

   _______________________________________________________________________________
4. Describe the rationale or methodology used to reach the diagnosis, as well as the symptoms that meet the criteria for diagnosis.

5. How would you describe the severity of this condition?

6. Does the student’s disability/health condition significantly limit any major life activities? If yes, please describe the limitations and/or restrictions in detail.
7. Please state the specific recommendations regarding the accommodations this student needs, explain why such accommodations are warranted, and how the requested accommodations will reduce the effects that the student’s disabilities may have on academic performance and life functioning?

[Blank space]

8. List current treatments and accommodations, including therapy, assistive devices, and medication (including dosage and frequency).

[Blank space]

9. Please include any other information that may help us accommodate this student.

[Blank space]

10. For how long do you consider the information you provide in Items 1-9 to be valid without reassessment and/or updated information?
   ☐ The circumstances described in this form are permanent and stationary.
   ☐ The circumstances described in the form may not be permanent or stationary, but I expect no significant change through ____________, __________.
      
      month     year

11. If you are related to the applicant what is your relationship? __________________________
All fields below must be completed to process.

Signature of Provider ____________________________ Date ______________

Print Name & Title: _____________________________________________________________

Address: _____________________________________________________________________

Phone Number: __________________________________________________________________

Email: ________________________________________________________________________

Provider’s Clinic Stamp or License Number/State Here:

(non-licensed professional should include a business card)