VALPARAISO UNIVERSITY

Access and Accommodations Resource Center

Dear Provider:

The following student _____ , DOB _____ has requested accommodations through the Access and Accommodations Resource Center (formerly known as Disability Support Services) at Valparaiso University. Under the Americans with Disabilities Act of 1990 (2008) and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities may be entitled to reasonable accommodations. However, in order to determine eligibility and justify appropriateness of accommodations, there is a need for documentation to verify the student's diagnosis(es), as well as the impact of this diagnosis on one or more major life activities.

We respectfully ask that you complete all sections of this form and have it returned to the staff in the Access and Accommodations Resource Center (AARC) as soon as possible. Completed forms may be scanned in and emailed to our secure server, aarc@valpo.edu and/or mailed to the address below.

Please note that any documentation provided to the AARC remains confidential. No information concerning accommodations or documentation will be released or discussed without written consent from the student.

Thank you in advance for your cooperation with this process.

Sincerely,

Christina Hearne, MPA

Christina Hearne
Director, Access and Accommodations Resource Center

Donelle Henderlong, MS

Donelle Henderlong
Coordinator, Access and Accommodations Resource Center

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Student Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Diagnostic Information

Primary Diagnosis _____ Date of Diagnosis_____

Secondary Diagnosis_____ Date of Diagnosis _____

Are there additional diagnoses our office should be aware of? If so, please list below.

_____

Is primary diagnosis expected to be valid for 6 months or longer?

[ ] Yes

[ ] No (Please list expected duration of diagnosis _____)

How was this diagnosis concluded? (Please check all that apply?)

[ ] Interview with patient

[ ] Interview with relative/ supporter of patient

[ ] Behavioral Observations

[ ] Educational History

[ ] Developmental History

[ ] Testing (**please provide most current copy),** including, but not limited to**:**
Neuro-physcological Testing
Educational Testing
Psychological Testing

[ ] Other (please specify)

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Please rate the level of impact of the diagnosis(es) on the following major life activities based on a scale of 1-10. **(1= least impact; 5= Moderate impact; 10= Most impact). For activities not impacted, please indicate "N/A"**

- Concentration _____
- Memory _____
- Socialization _____
- Speaking _____
- Hearing _____
- Physical Mobility _____
- Learning _____
- Reading _____
- Processing _____
- Communicating _____
- Sleeping _____
- Managing distractions internal / external _____
- Executive functioning _____
- Organization _____

Please use this extra space to include further rationale or other areas of note

Please describe how the above limitations may manifest in the college environment

In the Classroom Environment	
In the Testing Environment	
While completing Homework	
In an applied setting, such as a lab or field placement.	

Additional Comments

Please include any additional information that you feel may help us better assist this student

VALPARAISO UNIVERSITY

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Certifying Medical Professional

Signature of Medical Professional

Date

License #

Printed Name and Title

Phone #

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