Student Accessibility Resources

Grand Valley State University

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www.gvsu.edu/accessibility

DISABILITY DOCUMENTATION FORM:

MOBILITY/MOTORIC

(Including Little person/Dwarfism and hands/Arms)

The office of Student Accessibility Resources (SAR) strives to ensure that qualified persons with chronic health conditions are accommodated, and if possible, that their accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Grand Valley State University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the University's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a chronic health condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

This form is designed to allow us to achieve these goals. Persons who wish to receive accommodations due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the person's condition, must have experience diagnosing and treating condition, and will be an impartial professional who is not related to the patient. **NOTE: Form may not be used as documentation for Assistance Animals.** Please complete all blanks on this document. If any information is left unanswered, this documentation will not be accepted.

The Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment." Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Client Information (to be completed by the client)

Last Name: _____ First _____ Middle Initial _____

Date of Birth: _____ Client's GVSU G#: _____

Certifying Professional (to be completed by the certifying professional)

Certifying Professional's Full Name: _____

Credentials/Specialization: _____

License Type: _____

License #: _____ State _____ Exp. Date _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Area Code: (_____) Phone Number _____

Fax Area Code: (_____) Fax Number _____

Email: _____

Please Attach Business Card Here

OR

If Submitting Electronically,

Denote your Office Web Address

Office web address: _____

Diagnosis/Diagnoses: Please include DSM or ICD Codes and name of condition(s)

_____
_____
_____

Date of onset: _____ Date of diagnosis: _____

Diagnostic Tools: How did you arrive at your diagnoses? Describe diagnostic tools and assessments you have used:

☐ Medical testing or evaluation (e.g. MRI, X-ray, Physical exam):
_____
_____

☐ Interviews with the client

☐ Interviews with other persons

☐ Medical history

☐ Self-rated or interviewer rated scales

☐ Other

Client's last appointment: **(Check One)**

☐ Less than a Month ☐ Less than a year ☐ Greater than one year

Please record the client's appointment/treatment frequency:

_____
_____

Characteristics of Limiting Condition(s): **(Check Appropriate Terms)**

☐ Permanent ☐ Temporary ☐ Stable ☐ Episodic

☐ Slow Progression ☐ Rapid Progression ☐ Improving

If temporary, expected duration until: _____

Additional comments/information:

_____
_____

Medication, Treatment, and Prescribed Aids

What treatment, medication and prescribed aids are currently being used to address the diagnosis/diagnoses above?

_____
_____

Does the client use any of the following aids for mobility? (Check all that apply)

☐ Manual wheelchair ☐ Power-Assisted wheelchair ☐ Electric wheelchair

☐ Powered Scooter ☐ Knee Scooter ☐ Prosthetic ☐ Cane

☐ Crutches ☐ Walker ☐ Brace/Orthotics/AFO ☐ Wheeled caddie

☐ Service dog ☐ Personal Assistant Services (PAS)

Can the client walk more than **200 feet** without having to stop and rest?

Yes ☐ No ☐ If no, expected duration until: _____

Is the client authorized for State of Michigan Handicap Parking?

Yes ☐ No ☐ If yes, expected duration until: _____

Fully describe impact of medication side-effects that may adversely affect the client's academic or workplace performance:

_____
_____
_____
_____

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please explain:

_____
_____
_____
_____

Implications for Workplace or Academic/Student Life

For each major life activity listed, denote whether there is impact from the medical condition. For each major life activity marked, provide an explanation to the right. (e.g., is impact episodic? permanent? How long does impact last? What is the level of severity?) As this is not a comprehensive list of major life activities, feel free to use the "other" spaces at the bottom if needed.

Life Activity: Eating

Substantial Impact? Yes ☐ No ☐

Explanation:

_____
_____
_____
_____

Life Activity: Walking (Can or cannot ambulate 200 feet without assistance?)

Substantial Impact? Yes ☐ No ☐

Explanation:

_____
_____
_____
_____

Life Activity: Gross motor movements (standing, bending, lifting, carrying items)

Substantial Impact? Yes ☐ No ☐

Explanation:

_____
_____
_____
_____

Life Activity: Fine motor movements (typing, writing, texting, grasping, holding items)

Substantial Impact? Yes ☐ No ☐

Explanation:

_____

_____
_____
_____

Life Activity: Self-care (activities of daily living, i.e., dressing, bathing, personal hygiene, etc.)

Substantial Impact? Yes ☐ No ☐

Explanation:

_____
_____
_____
_____

Life Activity: Other (explain)

Substantial Impact? Yes ☐ No ☐

Explanation:

_____
_____
_____
_____

Life Activity: Other (explain)

Substantial Impact? Yes ☐ No ☐

Explanation:

_____
_____
_____
_____

Please describe any additional characteristics of the condition that result in limitations relative to academic or workplace performance, or use this space to further comment on any of the impacted major life activities:

_____
_____
_____
_____

From your perspective, describe possible accommodations that could facilitate academic or workplace performance:

_____
_____
_____
_____

Using the contact information on page one, print, sign below, and fax/send directly to Student Accessibility Resources.

Date: _____

Certifying Professional Signature: _____

Signature denotes content accuracy, adherence to professional standards and guidelines on page 1 of this document.