CULearn
MENTAL HEALTH DISABILITY DOCUMENTATION

CONCORDIA UNIVERSITY CHICAGO
1864

The student whose name appears below is seeking accommodations based on the diagnosis of one or more disabilities. The student is requesting that the documentation of the diagnosis be provided to the Academic Support Coordinator at Concordia University Chicago. Documentation is required to verify the student's eligibility for accommodations under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990. This form must be completed by an appropriate licensed medical provider. Additional information, such as reports of testing results, may be appended to this form. All materials should be returned to the CULearn Academic Support Coordinator:

Mail: **CULearn Academic Support Coordinator**
Christopher Center 248
Concordia University Chicago
7400 Augusta Street
River Forest, Illinois 60305

Email: Accessibility@CUChicago.edu

STUDENT'S IDENTIFICATION INFORMATION

Name: _____ Birthdate: _____ H Number: _____

CLINICAL PROVIDER'S INFORMATION

Name: _____ Credentials: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone Number: _____ Professional License Number: _____

Credentials & License Type: _____

Date of Initial Contact with Student: _____ Date of Most Recent Clinical Contact with Student: _____

STUDENT'S MEDICAL INFORMATION

Diagnosis & Diagnostic Code (Indicate whether from DSM-5 or ICD-10):

Date of Diagnosis: _____

Name of Diagnosing Clinician: _____

Form continued on page 2.

The ADA laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. In which major life activities does the student's diagnosis pose substantial limitations?

Describe the functional impact of the diagnosis on the student's abilities:

Level of current functioning (with benefits of treatment):

Impairment of learning abilities (concentration, memory, processing speed, etc.):

Does this person pose a threat to self or others (explain)?

Is this person currently receiving regular counseling? ☐ Yes ☐ No

Current medications and dosages:

Medication side effects:

Form continued on page 3.

Current compliance with medication and treatment plan:

History of hospitalization(s):

CLINICAL PROVIDER'S RECOMMENDATIONS

Describe suggested accommodations and state how each would remove barriers to access for the student.

RESTRICTIONS

What academic course load do you recommend for this student?

I certify that the information stated above is correct based on my professional judgment.

Provider's Signature Date