

## Documentation for Mobility Impairments

Clayton State University's Disability Resource Center provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. The Disability Resource Center will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. All parts of this form must be completed as thoroughly and legibly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process for the student.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in the Disability Resource Center. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic needs.

After completing this form, sign it, complete the Healthcare Provider Information section on the last page and return it to the student, who will give it to the Disability Resource Center staff at Clayton State University.

To view the USG BOR disability documentation criteria, please visit the following website:  
[https://www.usg.edu/academic\\_affairs\\_handbook/section3/C793](https://www.usg.edu/academic_affairs_handbook/section3/C793).

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Date	Student Name (Print)	Student ID#

**Primary Diagnosis:** \_\_\_\_\_

Date of onset: \_\_\_\_\_

**Additional Diagnosis:** \_\_\_\_\_

Date of onset: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Frequency of office visits: \_\_\_\_\_

Describe the history, current symptoms and severity of the condition.

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Describe the functional/physical limitations that affect the student's ability to conduct major life activities.

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Describe expected progression or stability of the disorder.

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Describe the current functional limitations which affect the student in the academic setting.

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### HEALTHCARE PROVIDER INFORMATION

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Name (Print): \_\_\_\_\_

Title: \_\_\_\_\_ License #: \_\_\_\_\_

