REQUEST FOR DOCUMENTATION OF DISABILITY
SAINT MARY'S COLLEGE OF CALIFORNIA

RETURN COMPLETED FORM TO:
STUDENT DISABILITY SERVICES
FILIPPI ACADEMIC HALL, RM 190

P.O. BOX 3326
MORAGA, CA 94575-3326
OFFICE: (925) 631-4358 FAX: (925) 631-4164

PART I. TO BE COMPLETED BY THE STUDENT:

I hereby authorize the release of all information with respect to my physical or mental health as requested on this document. I further authorize the health care provider named on this form and the Director or student's case coordinator in Student Disability Services and/or the Assistant Vice Provost of Undergraduate Academics at Saint Mary's College of California to discuss confidential medical or mental health related information relevant to my request for accommodation(s) from the College.

Student's Last Name (please print)	**First Name**	**M.I.**	**SMC Student ID #**

Student's Signature _____ **Date** _____

PART II. TO BE COMPLETED BY THE APPROPRIATE TREATING AND LICENSED NON-FAMILIAL HEALTH CARE PROFESSIONAL:

Please add additional pages as appropriate to fully describe condition, limitations, and/or recommendations.

CERTIFYING PROFESSIONAL & TITLE: (please print)	**LICENSE #:**

DIAGNOSIS & RELEVANT SYMPTOMS:

_____

_____

HISTORY AND PROGNOSIS: MM / DD / YYYY

1. Date condition(s) was first diagnosed: _____/_____/_____
2. Date student first visited you for this condition(s): _____/_____/_____
3. Date student was most recently seen for this condition(s): _____/_____/_____
4. Expected duration of condition(s): _____

ASSESSMENT OF LIMITATIONS OR AFFECTS CONDITION MAY HAVE (OR HAD) RELATED TO NORMAL LIFE ACTIVITIES AND THE COLLEGE ENVIRONMENT:

_____

_____

_____

_____

PART II. (CONTINUED) PLEASE INDICATE THE IMPACT OF THE DISABILITY AND/OR ITS TREATMENT.

	N / A	MODERATE IMPACT	SEVERE IMPACT	DESCRIBE IMPACT IF MODERATE OR SEVERE:
Treatment / Medication Side Effects	☐	☐	☐	
Pain	☐	☐	☐	
Walking / Standing / Sitting	☐	☐	☐	*Include distance / duration / assistive devices*
Performing Manual Tasks i.e. writing, keyboarding	☐	☐	☐	*Include duration*
Breathing	☐	☐	☐	
Hearing / Vision	☐	☐	☐	
Sleeping	☐	☐	☐	
Delusions / Hallucinations	☐	☐	☐	
Obsessions / Compulsions	☐	☐	☐	
Mood / Emotional Regulation	☐	☐	☐	
Hyperactivity / Impulsivity	☐	☐	☐	
Organization / Executive Functioning	☐	☐	☐	
Concentration / Sustained Focus	☐	☐	☐	
Memory	☐	☐	☐	
Thinking / Learning	☐	☐	☐	
Social Skills / Interactions	☐	☐	☐	
Verbal Communication / Speech	☐	☐	☐	
Other	☐	☐	☐	

CERTIFYING PROFESSIONAL'S SIGNATURE: _____ **DATE**_____

PRACTICE NAME: _____

STREET ADDRESS: _____ CITY, STATE, ZIP/POSTAL _____

TELEPHONE NUMBER_____ FAX NUMBER_____