DEPARTMENT OF
ACCESSIBILITY &
LEARNING EXCELLENCE

REQUEST FOR ACADEMIC ACCOMMODATIONS

_____ has reported a diagnosis of a disability to the Department of Accessibility and Learning Excellence at The College of Idaho. In order to determine if this person is eligible for reasonable accommodations, the College requires the student and appropriate medical professional (CERTIFYING LICENSED THERAPIST, COUNSELOR, PHYSICIAN, PSYCHIATRIST, OR CLINICAL PSYCHOLOGIST) provide the following information. **It is important that we have as much useful information as possible when determining a student's eligibility for services. Incomplete forms may result in the denial or delay of services.**

Section I

I hereby give permission for The College of Idaho DALE staff to request diagnostic information for determining eligibility for services/accommodations.

_____

Student Name Printed Student Signature

Section II

I. Specific medical diagnosis: _____
Level of severity:_____
Date of initial onset: _____
How often do you meet, or have you worked with this student? _____

II. Does this condition "substantially limit" one of the following major life activities?

☐ walking	☐ hearing	☐ seeing
☐ working	☐ performing manual tasks	☐ social interaction
☐ energy/motivation	☐ attention/focus	☐ other (describe):

_____

_____

_____

III. Please describe the functional limitations that are a result of the disability. Include a sense of severity, information on variability over time or circumstance, and potential environmental triggers.

IV. Provide a description of treatments, medications, assistive devices, accommodations and/or assistive services in current use and their estimated effectiveness in ameliorating the impact of the condition(s). Include any significant side effects that may affect physical, perceptual, behavioral or cognitive performance.

V. List recommended accommodations and services connected to the impact of the condition. When connections are not obvious they should be explained. Recommendations will be weighed as reasonable, and are no way guaranteed. Every accommodation should be followed by a justification for it based on the disability.

Provider Name & Title: _____

Address: _____

Phone: _____

License #: _____ Date: _____

Signature of Provider: _____

***Please Note**: The provider completing this form cannot be a relative of the student*

Please return form and direct any questions to:
Email: Accessibility@collegeofidaho.edu
Fax: 208-459-5108