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) 631-1122

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:

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

Effects/Symptoms Of Disability	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____