

DISABILITY SUPPORT RESOURCES

Grand Valley State University

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www.gvsu.edu/dsr

DISABILITY DOCUMENTATION FORM:

MOBILITY/MOTORIC

(Including Little person/Dwarfism and hands/Arms)

The office of Disability Support Resources (DSR) strives to ensure that qualified persons with chronic health conditions are accommodated, and if possible, that their accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Grand Valley State University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the University's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a chronic health condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

This form is designed to allow us to achieve these goals. Persons who wish to receive accommodations due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the person's condition, must have experience diagnosing and treating condition, and will be an impartial professional who is not related to the patient. **NOTE: Form may not be used as documentation for Assistance Animals.** Please complete all blanks on this document. If any information is left unanswered, this documentation will not be accepted.

The Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment." Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Client Information (to be completed by the client)

Last Name: _____ First _____ Middle Initial _____

Date of Birth: _____ Client's GVSU G#: _____

Certifying Professional (to be completed by the certifying professional)

Certifying Professional's Full Name: _____

Credentials/Specialization: _____

License Type: _____

License #: _____ State _____ Exp. Date _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Area Code: (_____) Phone Number _____

Fax Area Code: (_____) Fax Number _____

Email: _____

Please Attach Business Card Here

OR

If Submitting Electronically,

Denote your Office Web Address

Office web address: _____

Diagnosis/Diagnoses: Please include DSM or ICD Codes and name of condition(s)

Date of onset: _____ Date of diagnosis: _____

Diagnostic Tools: How did you arrive at your diagnoses? Describe diagnostic tools and assessments you have used:

Medical testing or evaluation (e.g. MRI, X-ray, Physical exam):

Interviews with the client

Interviews with other persons

Medical history

Self-rated or interviewer rated scales

Other

Client's last appointment: **(Check One)**

Less than a Month Less than a year Greater than one year

Please record the client's appointment/treatment frequency:

Characteristics of Limiting Condition(s): **(Check Appropriate Terms)**

Permanent Temporary Stable Episodic

Slow Progression Rapid Progression Improving

If temporary, expected duration until: _____

Additional comments/information:

Medication, Treatment, and Prescribed Aids

What treatment, medication and prescribed aids are currently being used to address the diagnosis/diagnoses above?

Does the client use any of the following aids for mobility? (Check all that apply)

- Manual wheelchair Power-Assisted wheelchair Electric wheelchair
- Powered Scooter Knee Scooter Prosthetic Cane
- Crutches Walker Brace/Orthotics/AFO Wheeled caddie
- Service dog Personal Assistant Services (PAS)

Can the client walk more than **200 feet** without having to stop and rest?

Yes No If no, expected duration until: _____

Is the client authorized for State of Michigan Handicap Parking?

Yes No If yes, expected duration until: _____

Fully describe impact of medication side-effects that may adversely affect the client's academic or workplace performance:

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please explain:

Implications for Workplace or Academic/Student Life

For each major life activity listed, denote whether there is impact from the medical condition. For each major life activity marked, provide an explanation to the right. (e.g., is impact episodic? permanent? How long does impact last? What is the level of severity?) As this is not a comprehensive list of major life activities, feel free to use the “other” spaces at the bottom if needed.

Life Activity: Eating

Substantial Impact? Yes No

Explanation:

Life Activity: Walking (Can or cannot ambulate 200 feet without assistance?)

Substantial Impact? Yes No

Explanation:

Life Activity: Gross motor movements (standing, bending, lifting, carrying items)

Substantial Impact? Yes No

Explanation:

Life Activity: Fine motor movements (typing, writing, texting, grasping, holding items)

Substantial Impact? Yes No

Explanation:

Life Activity: Self-care (activities of daily living, i.e., dressing, bathing, personal hygiene, etc.)

Substantial Impact? Yes No

Explanation:

Life Activity: Other (explain)

Substantial Impact? Yes No

Explanation:

Life Activity: Other (explain)

Substantial Impact? Yes No

Explanation:

Please describe any additional characteristics of the condition that result in limitations relative to academic or workplace performance, or use this space to further comment on any of the impacted major life activities:

From your perspective, describe possible accommodations that could facilitate academic or workplace performance:

Using the contact information on page one, print, sign below, and fax/send directly to Disability Support Resources.

Date: _____

Certifying Professional Signature: _____

Signature denotes content accuracy, adherence to professional standards and guidelines on page 1 of this document.