Manhattan Area Technical College
ACCOMMODATION RESOURCES
3136 Dickens Ave, Manhattan, KS 66503
Phone/Text: 785-367-3573
Email: accommodations@manhattantech.edu

Student Disability Documentation Form

This form must be completed by a licensed medical or mental health professional who does not have a family relationship with the student.

This form is made available to students at Manhattan Area Technical College and their medical and mental health care providers. This is an optional form intended to provide relevant information to accommodations on behalf of a student who is seeking academic or other accommodations for a disability. This form may be used in conjunction with, or in lieu of, other documentation provided by a licensed professional. Further information about the College's documentation guidelines for disability accommodations can be found on our website:

After the student submits this for to our office, we will review the information you provided and engage in an individualized and interactive process with the student to determine the student's accommodation needs and eligibility. At times, we may request additional or follow-up information from a healthcare provider, with permission from the student. Please note that students will have access to the information you provide on this form.

Pursuant to Title III of the Americans with Disabilities Act (ADA) of 1990, and Section 504 of the Rehabilitation Act of 1973, the College may not discriminate against a student based on their disability, and the student may be entitled to reasonable accommodations. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

Student Information

Full name (First then Last): _____

Date of Birth (MM/DD/YYYY): _____

Provider Information

Name of Provider: _____

Title/credentials: _____

Area of Specialization: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

Provider Signature: _____ Date: July 17, 2024

To enter signature electronically, please type your full name above and initial here: Electronic Signature

Diagnostic Information

Diagnoses/conditions. For each condition, please include severity and date of onset or date of initial diagnosis):

Dates or time frame during which student has been under your professional care: _____

Date student was last seen by you: _____

Number of times the student has met with you and/or frequency of appointments: _____

For mental health conditions: Is the student engaged in regular therapy or counseling? Yes ☐ No ☐ Not Sure ☐

If applicable: please include specific findings that support the diagnosis**,** such as relevant history, tests administered, test results, and interpretation of those test results. This information is especially relevant for learning disabilities and neurodevelopmental conditions, though it may apply to other medical conditions as well.

Symptoms and Functional Impact

For each diagnosis or condition, please include the following information:

The expected duration and progression of each condition (e.g., temporary vs. chronic, variable or progressive vs. stable, intermittent or episodic, in remission, etc)

The particular **symptoms** the student experiences, including the **frequency**, **severity**, and **duration** of symptoms:

How do these conditions impact the student's functioning, especially in the college setting? Please include a description of the physical and/or cognitive functional limitations due to the disability. Depending on the types of accommodations the student is seeking, this information may be specific to the impact on the student's academics and/or their physical activity limitations. For example, how and to what extent does the condition affect the student's ability to read, write, focus and concentrate, take tests, participate in class, attend class, sleep, eat, engage in movement or exercise, etc? Does this condition limit the student's functioning in any way or impose restrictions on any daily life activities? If so, how?

If applicable, describe any situations or environmental conditions that might lead to an exacerbation of symptoms:

If applicable: Please list any side effects the student may experience due to prescribed medications or medical treatments.

Accommodations and Supports

You are welcome to include recommendations for accommodations, supports, or resources that could be helpful for the student. There should be a logical link between the recommended accommodation(s) and the functional limitations described above. Not all recommended accommodations will necessarily be appropriate in a higher education setting, but we do take this information into account when fashioning a student's accommodation plan.