Office of Disability Services
Brescia University
717 Frederica Street
Owensboro, KY 42301

Student Information:

Name:_____ Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Email:_____Student ID: _____

I hereby authorize _____to release/discuss the information below.

Signature of Student:_____Date:_____

The Office of Disability Services at Brescia University facilitates and assists students with documented disabilities, as defined by the ADA, to receive reasonable accommodations. Accommodations are determined on an individual basis based on a review of the submitted documentation from a medical professional and any information gathered from the student. If the submitted documentation does not support the requested accommodations, additional documentation may be needed.

DIAGNOSTIC INFORMATION
(to be completed by medical practitioner/specialist)

1. Please specify the specific diagnosis(es)/disability. For psychological disabilities, please indicate both the name of the diagnosis, and the diagnostic taxonomy that was used.
   _____
   _____
   _____
   _____

   Diagnostic taxonomy used: ☐ DSM (IV-TR or 5) ☐ ICD (9 or 10) ☐_____

   If applicable, please rate the level of severity of the student's diagnosis?

   ☐ Mild ☐ Moderate ☐ Severe

   Duration of condition: ☐ Permanent ☐ Temporary (specify length of time)_____

   Date of Diagnosis:_____ Date of last contact with student:_____

2. How did you arrive at your diagnosis? Please check all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

   - ☐ Behavioral Observations/Development History
   - ☐ Medical History
   - ☐ Rating Scales (e.g., CAARS, Brown ADD Scales for Adults)
   - ☐ Neuro-Psychological Testing, Date(s) of Testing _____
   - ☐ Psycho-Educational Testing, Date(s) of Testing _____
   - ☐ Structured/unstructured student interviews
   - ☐ Other (please specify): _____

3. Please indicate the level of impact the student's disability may have in limiting the following major life activities:

Life Activity	**Mild**	**Moderate**	**Severe**	**Unknown/ NA**
Mobility				
Concentration				
Memory				
Social Interactions				
Organization				
Attendance				
Speaking				
Writing				
Reading				
Thinking (processing speed)				
Time Management				
Stress Management				
Managing internal distractions				
Managing external distractions				
Eating				
Sleeping				
Self-care				
Other:				

4. Please describe any major activities impacted by the disability or symptoms that may need to be addressed in the college environment, and any specific recommendations for accommodations:

_____

_____

_____

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon written request.

Provider Name (PRINT): _____

Provider Signature: _____ Date: _____

Title: _____

License or Certification #_____ National Provider Identifier (NPI): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

This form may be sent as an email attachment to **disability.services@brescia.edu**.