DOCUMENTATION OF DISABILITY FORM

NOTE: Please have a qualified healthcare professional complete this form. The information obtained from this form is intended to certify the presence of a disability that would qualify a student for academic accommodations at Ensign College. It is not intended to certify disability for other purposes.

Student Legal Name: ___________________________  ID#: __________________  Birth Date: __________________

A student has a disability if he or she has an impairment that substantially limits one or more major life activities or has a record of such an impairment, and the impairment has lasted or is expected to last six months or more. An impairment need not prevent or severely or significantly restrict a major life activity to be considered substantially limiting.

1. Does the student have a physical or mental impairment?  Yes ☐  No ☐

   a) If yes, what is the name of the impairment(s)? (Preferably including diagnostic code):

   _____________________________________________________________

   _____________________________________________________________

   b) Symptoms:

   _____________________________________________________________

   _____________________________________________________________

   c) Expected duration of the condition: ____________________________

In answering the following questions, please consider the student’s limitations when his or her condition is in an active state and if no mitigating measures are used. Mitigating measures are things like medications, prosthetic devices, assistive devices, or learned behavioral or adaptive neurological modifications that an individual may use to eliminate or reduce the effects of an impairment.

2. Does the impairment substantially limit a major life activity as compared to most people in the general population?  Yes ☐  No ☐

   If yes, what major life activity(s) or major bodily function(s) is/are affected? (Check all that apply)

<table>
<thead>
<tr>
<th>Major Life Activities</th>
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</tr>
</thead>
<tbody>
<tr>
<td>□ Bending</td>
<td>□ Hearing</td>
<td>□ Reading</td>
<td>□ Standing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>□ Breathing</td>
<td>□ Interacting with others</td>
<td>□ Seeing</td>
<td>□ Thinking</td>
<td></td>
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<tr>
<td>□ Caring for self</td>
<td>□ Learning</td>
<td>□ Sitting</td>
<td>□ Walking</td>
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<tr>
<td>□ Concentrating</td>
<td>□ Lifting</td>
<td>□ Sleeping</td>
<td>□ Working</td>
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<tr>
<td>□ Eating</td>
<td>□ Performing manual tasks</td>
<td>□ Speaking</td>
<td>□ Other: (describe)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Major Bodily Functions</th>
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</thead>
<tbody>
<tr>
<td>□ Bladder</td>
<td>□ Circulatory</td>
<td>□ Musculoskeletal</td>
<td>□ Other: (describe)</td>
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<tr>
<td>□ Bowel</td>
<td>□ Digestive</td>
<td>□ Neurological</td>
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<tr>
<td>□ Brain</td>
<td>□ Endocrine</td>
<td>□ Normal cell growth</td>
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<tr>
<td>□ Cardiovascular</td>
<td>□ Immune System</td>
<td>□ Respiratory</td>
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</tbody>
</table>
3. Does the impairment limit the student’s ability to participate in and/or perform educational tasks?
   Yes ☐ No ☐

   If yes, how?
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

4. Accommodation recommendations: ________________________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

Name of Student: ________________________________________________________________

Provider Name (Printed): __________________________________________________________

Provider Signature: ____________________________ Date: _____________________________

Provider Credentials: ___________________________________________________________

Address: ________________________________________________________________________

City/State/Zip: __________________________________________________________________

Phone: (_______) __________________________ Fax: (_______) _________________________

This section to be completed if provider is working under a supervisor’s license

Licensed Supervisor Name (Printed): ________________________________________________

Licensed Supervisor Credentials: ___________________________________________________

Licensed Supervisor Signature: ____________________________ Date: ____________________