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)

Major Life Activities

☐ Bending	☐ Hearing	☐ Reading	☐ Standing
☐ Breathing	☐ Interacting with others	☐ Seeing	☐ Thinking
☐ Caring for self	☐ Learning	☐ Sitting	☐ Walking
☐ Concentrating	☐ Lifting	☐ Sleeping	☐ Working
☐ Eating	☐ Performing manual tasks	☐ Speaking	☐ Other: (describe)

Major Bodily Functions

☐ Bladder	☐ Circulatory	☐ Musculoskeletal	☐ Other: (describe)
☐ Bowel	☐ Digestive	☐ Neurological	
☐ Brain	☐ Endocrine	☐ Normal cell growth	
☐ Cardiovascular	☐ Immune System	☐ Respiratory	

DOCUMENTATION OF DISABILITY FORM (CONTINUED)

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:**_____