

**Lake Michigan College Student Outreach and Support Services
Serving Benton Harbor, South Haven, and Niles Campuses
2755 E. Napier Ave Benton Harbor, MI 49022
Phone: (269) 927-8866 Fax: (269) 927-6536**

**DISABILITY DOCUMENTATION FORM:
CHRONIC HEALTH CONDITIONS**

PLEASE REVIEW CAREFULLY

The individual named below has applied for services from the Student Outreach and Support Services (SOSS) at Lake Michigan College. Lake Michigan College provides academic accommodations to individuals with disabilities. Individuals seeking services must provide appropriate medical documentation of their condition so that the SOSS can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

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.

Documentation required to verify the condition, severity, and functional limitations includes completion of this form or provision of equivalent information to the SOSS by a licensed medical professional with appropriate training and credentials. Professionals completing this form must have first-hand knowledge of the condition, experience in working with students with chronic health conditions and ideally a familiarity with the physical, emotional and cognitive demands experienced by students in an academic setting. Diagnoses of disabilities documented by family members are unacceptable.

MSU RCPD Disability Documentation: Chronic Health Conditions

Client name: Last, First, Middle Initial _____

Date of Birth: _____ LMC Student ID (eight digits): _____

Certifying Professional's Printed Name: _____

Credentials/Specialization: _____

License Type: _____

License #: _____ State: _____ Exp. Date _____

Mailing Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Email: _____

Attach Business Card Here
or
If Submitting Electronically,
Denote your Office Web Address

Office web address _____

Diagnosis/Diagnoses: _____

Date of onset: _____ Date of diagnosis: _____

Diagnostic Tools: How did you arrive at your diagnosis/diagnoses? Please check any relevant items below:

- | | |
|---|---|
| <input type="checkbox"/> Interviews with the client | <input type="checkbox"/> Interviews with other persons |
| <input type="checkbox"/> Medical testing (e.g. MRI) | <input type="checkbox"/> Developmental history |
| <input type="checkbox"/> Medical history | <input type="checkbox"/> Neuro-psychological testing |
| <input type="checkbox"/> Psycho-educational testing | <input type="checkbox"/> Self-rated or interviewer rated scales |
| <input type="checkbox"/> Other _____ | |

Prognosis

Expected Duration of Primary Condition: (Check One)

- Permanent Temporary

Characteristics of Limiting Condition(s): (Check All That Apply)

- Stable Episodic Slow Progression Rapid Progression
- Improving

Additional comments/information

Medication, Treatment, and Prescribed Aids

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

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:

Please record the client's appointment/treatment frequency:

Implications for Academic/Student Life

Major Life Activity	Explanation of Impact Please describe the impact of your client's condition as it applies to each major life activity	Recommendations for Accommodations and Services Please provide specific recommendations to address impacted major life activities
Concentration		
Long Term Memory		
Short Term Memory		
Sleeping		
Eating		
Bodily functions (e.g. digestive, endocrine functions)		

MSU RCPD Disability Documentation: Chronic Health Conditions

Self-Care		
Gross motor movements (lifting, bending, standing)		
Fine motor movements (typing, writing)		
Walking (e.g. how far?)		
Motivation		
Pain/pain management (how severe?)		
Stress Management		
Other (Explain): _____		
Other (Explain): _____		

Using the contact information on page one, print, sign below, and fax/send directly to the Student Outreach and Support Services.

Date:

Certifying Professional's Signature:

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