Disability Determination Form

Disability Services
4400 University Drive, MS 5C9, Fairfax, Virginia 22030
Student Union Building I (SUB I)
Phone: 703-993-2474; Fax: 703-993-4306
Email: ods@gmu.edu
Website: http://ds.gmu.edu

Dear Healthcare Professional:

Your patient/client, _____, wishes to register with Disability Services at George Mason University. The Disability Services office provides academic services and accommodations for students with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973 and with the Americans with Disabilities Act (ADA) of 1990 as amended in 2008. The ADA states the following:

> The term "disability" means with respect to an individual –
>
> A. A physical or mental impairment that substantially limits one or more major life activities of such individual:
> B. A record of such an impairment; or
> C. Being regarded as having such an impairment,

In order for a student to be considered eligible to receive academic accommodations, documentation must show functional limitations that impact the individual in an academic setting. Individuals requesting accommodations must disclose the nature of their impairment and provide recent documentation that verifies their condition. When providing information necessary to evaluate eligibility for academic accommodations, please adhere to the following:

- **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These professionals are generally trained, certified, or licensed psychologists or members of a medical specialty.
- **Complete the attached form as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting may delay the eligibility review process by necessitating follow-up contact for clarification. This form can also be completed by typing information into the fillable PDF form available on our website at ds.gmu.edu.
- **The healthcare professional should attach any reports that provide related information (e.g. psycho-educational testing, neuropsychological test results, medical evaluation results, etc.).** If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Please do not provide case notes or rating scales without a narrative that explains the results.
- **After completing the attached form, sign it and complete the Healthcare Provider Information section on the last page. The completed form can be mailed to our office, faxed (703-993-4306), or emailed as a PDF to ods@gmu.edu.** Information provided will not become part of a student's educational records, but it will be kept in the student's file within the Disability Services office where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any additional information that would be relevant to the student's academic adjustment.

If you have questions regarding this form or the Disability Services process, please call our office at 703.993.2474 or email ods@gmu.edu. Thank you for your assistance.

DISABILITY DETERMINATION FORM

Student Information
(Please Print Legibly or Type)

Name (Last, First, Middle): _____

Date of Birth: _____ G#: _____

Status: ☐ Current Student ☐ Transfer Student ☐ Prospective Student

Phone: ( ) - _____ Cell Phone: ( ) - _____

Address (Street, City, State, Zip Code): _____

_____

GMU Email Address: _____ @masonlive.gmu.edu

Personal Email Address: _____

To Be Completed by Healthcare Professional

Date last seen: _____

Impairment/Diagnosis (If applicable, include date of diagnosis and DSM-5/ICD-10 codes):

_____

_____

_____

Relevant patient/client history:

_____

_____

Additional psychosocial and contextual factors:

_____

_____

How was the impairment/diagnosis determined?

- ☐ Structured or unstructured interviews with the student
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental History
- ☐ Educational History
- ☐ Medical History
- ☐ Neuropsychological testing (dates of testing) _____
- ☐ Psycho-educational testing (dates of testing) _____
- ☐ Standardized or non-standardized rating scales
- ☐ Other (please specify) _____

How would you categorize this condition in terms of severity? Please check only one and explain below.

□ Minimal □ Moderate □ Severe □ Residual/Remission □ Other:_____

The condition is: ❑ Stable ❑ Prone to exacerbation ❑ Other: _____

Duration of impairment/diagnosis is: ❑ Permanent ❑ Temporary

Note Duration: _____ **or** Re-Evaluation Date: _____

Indicate major life activities that are affected because of the impairment and severity of those limitations. This list is not exhaustive and additional life activities can be added at the bottom of this chart.

Life Activity	Negligible	Moderate	Substantial	Don't Know	N/A
Breathing	❑	❑	❑	❑	❑
Concentrating	❑	❑	❑	❑	❑
Eating	❑	❑	❑	❑	❑
Emotional Processes	❑	❑	❑	❑	❑
Hearing	❑	❑	❑	❑	❑
Keeping Appointments	❑	❑	❑	❑	❑
Learning	❑	❑	❑	❑	❑
Lifting	❑	❑	❑	❑	❑
Managing External Distractions	❑	❑	❑	❑	❑
Managing Internal Distractions	❑	❑	❑	❑	❑
Manual Tasks	❑	❑	❑	❑	❑
Memory	❑	❑	❑	❑	❑
Organization	❑	❑	❑	❑	❑
Regular Attendance	❑	❑	❑	❑	❑
Seeing	❑	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	❑
Sitting	❑	❑	❑	❑	❑
Sleeping	❑	❑	❑	❑	❑
Social Interactions	❑	❑	❑	❑	❑
Speaking	❑	❑	❑	❑	❑
Stamina	❑	❑	❑	❑	❑
Stress Management	❑	❑	❑	❑	❑
Studying	❑	❑	❑	❑	❑
Taking Notes	❑	❑	❑	❑	❑
Taking Tests	❑	❑	❑	❑	❑
Thinking	❑	❑	❑	❑	❑
Walking	❑	❑	❑	❑	❑
Writing	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑

Specifically describe to what extent the impairment impacts the student's ability to function academically and in a college environment addressing any items endorsed on the previous page:

If applicable, list any medications currently prescribed and how they have an impact on the student's learning. Please also include any side effects and impact on academic performance:

Is this student currently receiving therapy or counseling? ❑ Yes ❑ No ❑ Not Sure

Please indicate specific recommendations regarding academic accommodations for this student and a rationale as to why these accommodations/adjustments/services are warranted based on the student's functional limitations. Indicate why the accommodations are necessary.

If current treatments (e.g., medication, therapy) are successful, please state the reason that the above academic adjustments, auxiliary aids, and/or services are necessary.

Is the student able, with reasonable accommodations, to take a full course load of 12 college credits?

❑ Yes ❑ No (Please explain below)

This student's diagnosis is significant enough to <u>severely</u> impair his/her ability to learn and express that learning within a college environment.

□ I Agree with this statement □ I Disagree with this statement

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.

Healthcare Professional Signature: _____ Date: _____

Healthcare Professional Name (Print): _____

Title: _____

License or Certification #: _____

Address: _____

_____

Phone: ( ) - Fax Number: ( ) -

Email Address: _____

****

Name of Person Completing Form: _____ Date: _____

Professional Affiliation/Title: _____

Important: After documentation is reviewed, Disability Services will send an email notification to the student's GMU email account acknowledging receipt of documentation and eligibility status.