Reminder: A copy of the most recent psycho-educational or disability-related evaluation is required to fully register with OAS. When primary documentation can be supplied, this document serves as a supplement to complete the file.

The Office of Accessibility Services at Simmons College requires that students with disabilities who request accommodations provide documentation from a licensed health professional (physician, psychiatrist, or other medical specialist). Documentation must support the need for accommodations as related to the status of the student’s disabling condition.

Scan to access@simmons.edu or U.S mail completed form to the address listed above.

Please have your licensed health professional complete the following information.

DIAGNOSIS INFORMATION

Diagnosis in the area(s) of:  □ ADHD □ Psychiatric □ Learning □ Medical

Primary Diagnosis(es) and results of evaluation (medical / DSM-IV or -V): __________________________________________________________

Date of establishment / Age of onset ___ / ___ / _____ Diagnosed by (provider’s name) ________________________________

Initial evaluation method(s): __________________________________________________________

Date of most recent evaluation ___ / ___ / _____ Evaluation type: □ Psycho-educational □ Disability-related

Evaluation method(s): __________________________________________________________

Schedule for re-evaluation: __________________________________________________________

BACKGROUND HISTORY

Please discuss any pertinent background information related to the diagnosis.

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________________________________________________________________________________________
EVALUATION PROCEDURES

Please list assessment or evaluation procedures, results, and any additional information related to the evaluation of the student’s disability. (e.g. specific testing, weekly therapy, check-in appointments)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

CURRENT IMPACT OF DIAGNOSIS

Please describe the student’s condition. We ask that you include how the condition impacts the student and the student’s educational history, level of impairment, progress and/or treatment as applicable.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Severity of symptoms:   □ Mild   □ Moderate   □ Severe

IMPACT ON MAJOR LIFE ACTIVITY IN ACADEMIC SETTING

Does the diagnosis constitute a current and substantial limitation on a major life activity (i.e. learning)?

□ YES   □ NO

Please describe the limitations on learning and the degree to which the student’s disability impacts academic performance and the student’s ability to meet the demands of the academic program.
CURRENT MEDICATIONS AND TREATMENT

Please list any prescribed medications, their dosages, and any adverse side effects, if applicable.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Condition is: □ Stable □ Prone to exacerbation □ Permanent/chronic □ Temporary

RECOMMENDATIONS / ADDITIONAL COMMENTS

Please provide a list of recommended accommodations and how they will address the student’s specific needs for a fair and equal opportunity to learn relative to same-aged college peers. Specific accommodations will be determined and approved by the Office of Accessibility Services.

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EVALUATOR QUALIFICATIONS

I understand that the information provided will become part of the student record and may be released to the student upon the student’s written request.

Printed Name of Verifying Evaluator ___________________________ Signature ___________________________

Title ___________________________ License Number ___________________________ Date ___ /___ /________

Address ___________________________ Phone ___________________________

City, State, Zip Code ___________________________ Fax ___________________________
Send completed form to:

Office of Accessibility Services
Simmons University
Center for Student Success
300 The Fenway
Boston, MA 02115

This form may also be scanned to access@simmons.edu