Disability Services for Students
2080 Seibert Administration Bldg.
1903 W. Michigan Ave.
Kalamazoo, MI, 49008

Phone (269) 387-2116
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Third-Party Documentation Form

Disability Services for Students (DSS) is committed to creating an inclusive and equitable educational environment for students with disabilities by partnering with students, faculty and staff. One path to access is the implementation of reasonable accommodations. The Americans with Disabilities Act of 1990 (ADA) the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973 requires that access be provided for individuals who have a physical or mental impairment that substantially limits one or more major life activities and/or have a record of such impairment. The purpose of this form is to assist Health Care Professionals in documenting a student's relevant medical information that may aid in the exploration of reasonable accommodations.
IMPORTANT: This form serves as one option (not the only option) for providing disability documentation to DSS; please review our Helpful Documentation Guidelines.

Please take note of the following as you complete this form:

● **The person completing this form should be a credentialed provider who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is a part of the student's treatment for a previously diagnosed condition.** These providers are generally trained, certified, or licensed to diagnose and/or treat medical conditions. Examples include: psychiatrist, psychologist, therapist, counselor, social worker, medical doctor, optometrist, speech-language pathologist.

- To avoid any conflict of interest, DSS will not accept documentation provided by family members, close relatives, and/or people not serving in official capacity with the student

● **Please complete all parts of this form as specifically as possible.** Inadequate information, illegible handwriting, or missing fields may delay implementation of reasonable accommodations. Even if the student does not have a diagnosis, please complete the rest of the form to the best of your ability.

● **We invite you to attach to this form any other documents or information you think would be relevant in determining the student's academic accommodations.**

- The student or provider should include any documents which provide related information (Educational records (IEP, 504, ETR, etc.), Medical Records, Audiology Report, or Vocational Assessment, Neuropsychological/Psychoeducational Evaluation etc. The aforementioned documentation can be submitted with or in lieu of this document.

● **The information you provide will be kept in the student's confidential and secure file at DSS.**

- DSS Records are part of a student's record and protected by FERPA. Information is kept confidential and disclosed to others only as permitted by FERPA. Please visit our FERPA Webpage for more information.

Please return the completed form to the student so they can upload it to us via our portal. You can also send it to us directly via email to dss-exams@wmich.edu or via fax to (269) 387-0633.

For questions, contact us through our webpage contact form or (269) 387-2116.

Student Information:

Student Name:

Date of Birth:

WMU WIN#:

Medical Information:

The remainder of this form must be completed by a qualified provider (See pg. 1)

The provider should use their own judgment to complete this form; Please share professional, objective information from your capacity in working with the student.

The more details a provider can give, the better we can help the student.

In what capacity do you work with the student:

Number of months or years working with the student:

Primary Diagnosis:

Severity (if applicable):

Secondary Diagnosis:

Severity (if applicable):

If there is no diagnosis or more diagnoses beyond the two above, please use the field below to provide information to help us have as complete a picture as possible:

1. Describe how and to what extent the condition(s) specifically impact the student:
Examples of areas of impact: reading, writing, hearing, concentrating, learning, etc.

2. If the condition is episodic/flares-up, please describe the frequency, duration, and any triggers:

3. List treatment plans, and/or side effects that may impact functioning:

4. Recommendations for reasonable accommodations at the university level:

Health Care Professional Information:

Date:

Health Care Professional Name:

Licensure/Certification Number:

Facility or Practice Name:

Address (Complete):

Phone Number:

FAX:

Health Care Professional Signature: