



Disability Support Services (DSS) Documentation Requirements

Policy

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide **current** (within 3 years) documentation of their disability. This documentation should provide information regarding the onset and severity in order to establish that an individual is covered under ADA and Section 504 of the Rehabilitation Act of 1973. Documentation must demonstrate that the individual has a disability and that it substantially limits some major life activity, including learning.

Procedure

The student is responsible for providing documentation that supports his/her request for accommodation services.

Please submit this signed Release of Information and required evaluation reports to:

**University of Wisconsin-Superior
Disability Support Services
Belknap & Catlin, PO Box 2000
Swenson Hall 1024
Superior, Wisconsin 54880**

**Phone: (715) 394-8188 or (715) 394-8019
Fax: (715) 394-8441**

RELEASE OF INFORMATION

I, _____, hereby authorize the release of requested information to **Disability Support Services at the University of Wisconsin-Superior** for the purpose of determining my eligibility for educational accommodation.

Date

Student Signature



1. Medical Diagnosis:

2. Date of most recent medical evaluation:

3. Severity of Disability:

4. Assessment procedures or evaluation instruments used to make this diagnosis, including results:

a. _____

b. _____

c. _____

d. _____

5. Disability related needs, including recommendations for academic accommodations, adjustments and/or auxiliary aids at the post-secondary level. The information provided in this will be used in determining what accommodations are appropriate and reasonable.

a. _____

b. _____

Disability Support Services



c. _____

d. _____

6. Describe any medication side-effects that may be anticipated:

7. Describe the prognosis and anticipated duration of the limitations described above:

Please attach any additional assessment information that might be helpful in providing appropriate accommodations, i.e. evaluations done by a speech pathologist, neuropsychologist, occupations therapist, physical therapist, etc. Thank you for your help in providing this information so that we may begin providing services as soon as possible. Please return this form to the address shown on page one.

Signature of medical doctor or other professional providing this information is required.

Physician's Name _____ License # _____
(or other professional) (Please Print)

Address _____ Phone _____

Signature _____

Disability Support Services