



MercyCollege

Office of Accessibility Documentation Form

(Please print)

Client/Patient's Name _____ Today's Date _____

Clinician's Name and Credentials _____

Clinician's Practice Name and Address _____

Clinician's Phone Number _____

Clinician's Signature _____

**PLEASE INCLUDE RESPONSES FOR EACH SECTION
FORM TO BE COMPLETED BY THE DIAGNOSING CLINICIAN**

Diagnosis and clinical description (please include DSM and/or ICF diagnostic codes when applicable): _____

Diagnosis date: _____

Duration: ___ Permanent ___ Chronic/recurring _____ Temporary (with end date)

What evaluation methods/procedures/assessments were used to diagnose the condition (please attach available diagnostic reports, i.e. test results)? _____

What are the symptoms **and** how might they limit the student's functioning in an educational setting?

Medications the person is currently taking (including any adverse side effects): _____

Academic modifications recommended: _____

Additional comments: