



Disability Documentation Form

This form must be completed by a qualified provider to be considered documentation for a disability.

Student Information

Last Name: _____ First Name: _____

Date of Birth: _____

Student ZID: _____ Year in School: _____

Phone: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Provider Information

Name: _____ Degree: _____

License #: _____ Title: _____

Phone: _____ Fax: _____

Email: _____ or Website: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Information released includes any confidential information to further support the request for accommodations. This information is used for the purpose of determining reasonable accommodations while the above student is attending Northern Illinois University.

By signing below, I certify all information is true and accurate to the best of my professional knowledge/opinion.

- I have diagnosed and/or I am currently treating the individual requesting this information for the condition stated on the form.
- The listed condition meets the criteria to be classified as a disability as defined by the Americans with Disabilities Act.
- I am not a family member and/or do not have a conflict of interest with this individual that would make it unethical to complete this form.

Signature: _____ Today's Date: _____

DISABILITY INFORMATION (All sections completed by the provider)

Please state the disability/disabilities (including ICD and DSM codes)

Date of Diagnosis: _____ Date of last contact with student:

Which major life activities (which includes but is not limited to caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working) are impacted

Describe the expected duration or progression of the disability and situations or environmental conditions that may exacerbate the student's symptoms.

Please describe the medications or treatment the student is prescribed including the effectiveness and potential side effects.

Falsifying information and/or signatures is a violation of the Student Code of Conduct and can result in a Conduct Investigation.

Describe how the disability may impact the student in an academic, residential, or dining setting.

Please list any accommodations that may best meet the needs of the student under Section 504 and Section 508 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act of 1990, and the ADA Amendments Act of 2008.

Provider Signature: _____ Date: _____

*If completed electronically, time stamp and written statement must be included. Office stamp with witness signature will also be accepted.

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