Student Accessibility Services
MILWAUKEE SCHOOL OF ENGINEERING

1025 N. Broadway St., Milwaukee, WI 53202
Tel: (414) 277-7281 Fax: (414) 277-7498

CERTIFICATION OF A DISABILITY

Milwaukee School of Engineering, provides accommodations to students with diagnosed disabilities, chronic medical conditions, and mental health conditions in accordance with the Americans with Disabilities Act (ADA), and Sections 504 of the Rehabilitation Act of 1973. To determine eligibility for services, this office requires current and comprehensive documentation of the disability from the diagnosing physician or other appropriate professional. The student, named below, is requesting services from our office at this time. In order to help us service this student, please complete the following form and return it to Student Accessibility Services. ***Final determination of appropriate accommodations will be determined by Student Accessibility Services.***

The information that you provide will not become part of the student's educational records and will be kept in the student's confidential file at Student Accessibility Services. ***In addition to the requested information, please attach any additional information, for example, your assessment report and any test results.*** *Services will not be available to this student until this form has been received. If you have any questions, please do not hesitate to contact our office at 414-277-7281 or moureau@msoe.edu.*

_____To Be Completed by Student_____

Name of Student:_____ Student's DOB: _____

Name of Provider: _____ Title/ License of Provider: _____

_____To Be Completed by Provider_____

How long have you overseen this student's care? _____ Date of last contact with student:_____

Please list any relevant DSM/ ICD Diagnosis with the date of diagnosis

Is this condition: (Check all that apply)

☐ Chronic ☐ Temporary (if yes, expected duration or re-evaluation date) _____

☐ Stable ☐ Unstable

☐ Symptomatic Daily ☐ Episodic (if yes, please provide a statement of frequency)_____

☐ Prone to exacerbation (if yes by what?) _____

Please describe the nature of their disability and any functional limitations created by it. Please include statements of frequency and severity of symptoms.

ADA defines a major life activity as activities that you do every day, including your body's own internal processes. Please indicate the impact of the client's condition on each of the following major life activities:

Life Activity	**Mild**	**Moderate**	**Substantial**	**N/A**	**Comments**
Operation of a major body function					
Mobility					
Sight					
Hearing					
Speaking					
Reading (comprehension, fluency or speed)					
Writing (expression and fine motor skills)					
Auditory processing					
Thinking and processing information, including slower processing speed					
Focus and concentration					
Communication					
Interacting with others					
Activities of daily living					
Other:					

Please indicate the current treatment plan for the above mentioned diagnosis. For any pharmaceuticals please indicate medication, dosage and possible side effects:

What, if any, accommodations do you recommend being provided to help ensure his/her equal access and/or full opportunity to participate in our services? For each recommendation, please explain how that accommodation will ameliorate a substantial limitation of a major life activity.

In your professional opinion, does this student's diagnosis impact them to the level of meeting the criteria of a disability?

"The ADA defines a person with a disability is someone who: has a physical or mental impairment that substantially limits one or more major life activities, has a history or record of such an impairment (such as cancer that is in remission), or is perceived by others as having such an impairment (such as a person who has scars from a severe burn)"

☐ Yes ☐ No

Is there anything else you would like us to know about this student (please attach additional pages as necessary)?

PLEASE ATTACH A COPY OF ANY DIAGNOSITIC REPORTS, PSYCHOEDUCATIONAL ASSESSMENTS, OR NEUROPSYCHOLOGICAL EVALUATIONS ASSOCIATED WITH THIS CASE.

If the above information is being provided by someone other than the professional who made the diagnosis, please provide the name, and contact information for the person who made the diagnosis:

Name: _____ Title/ License: _____

Phone Number: _____Organization or Clinic Affiliation: _____

Provider completing form:

_____ _____
Signature of Professional Completing Form Date

_____ _____
Professional's name (printed) and Title License No.

_____ _____
Address Telephone No.

_____ _____
E-mail Address Fax No.

SAS 10/23