



DOCUMENTATION OF VISUAL/HEARING DISABILITY

RELEASE:

I, _____, hereby authorize the release of the following information to Disability Services at Willamette University for the purpose of determining my eligibility for academic accommodation.

Student's Signature: _____ Date: _____

TO BE COMPLETED BY A QUALIFIED HEALTH PROFESSIONAL

The student named above is requesting disability-related accommodations from Willamette University. The student has authorized a release of medical information to the Director of Disability Services. This information will be held in strict confidence and will be used solely to determine the student's eligibility for services as mandated under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, and in determining the most appropriate accommodations based on the student's current level of functioning. *It will not become part of the student's permanent academic file.* Please help us to make the best possible decision by carefully filling out this form and attaching any other pertinent records. Thank you.

Diagnosis: _____

Please indicate level of hearing/vision. _____

Please describe the diagnosis *in layman's terms*: _____

Date of diagnosis/onset: _____

Prognosis: Permanent Temporary Stable Progressive

If temporary, expected duration: _____

Does the disability limit/impact activities associated with university attendance?

No Yes If yes, indicate what type of activities and to what extent:

Does this disability affect academic pursuits (e.g., cognition, attention, vision, hearing)?

No Yes If yes, explain to what extent: _____

(Continued on other side)

What treatment or assistive technology, if any, is the student currently utilizing? If medication has been prescribed, please indicate name and dosage. Are there side effects which may interfere with the student's functioning? _____

Date of last visit: _____

Frequency of monitoring: _____

The University provides academic services and accommodations to ensure equal access to its programs by persons with disabilities. What recommendations do you have that would assist the student in the academic setting? _____

Additional comments: _____

HEALTH PROFESSIONAL

Name: _____

Signature: _____

Position: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

License #: _____

Date: _____

Please return to: Director of Disability Services
 Willamette University
 900 State Street
 Salem, Oregon 97301