Dallas Theological Seminary Learning Disability Documentation Form

Return completed form to Disability Services at disability@dts.edu or fax 214-887-5516

This form will not be accepted as documentation of physical or psychological conditions.

Student's Name (First Name Last Name): ____

To Whom It May Concern:

The above named student has requested modifications based upon a disability at Dallas Theological Seminary. In order to determine eligibility, Dallas Theological Seminary requires documentation from the appropriate health care professional (e.g. medical doctor, nurse practitioner, physical or occupational therapist, physiatrist). This documentation will be used to determine if the student's health condition rises to the level of disability as defined by the Americans with Disabilities Act of 1990. The health condition must represent a "substantial limitation" on a "major life activity."

A "major life activity" includes, but is not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working. It also includes "the operation of a major bodily function, including but not limited to, functions of the immune system, special sense organs and skin, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, reproductive functions, genitourinary, or the operation of an individual organ within a body system. A "substantial limitation" is defined as substantially limited as compared to most people in the general population.

Please answer the following questions as completely as possible. Feel free to write on the back of the form if you need additional space. Dallas Theological Seminary sincerely appreciates your time and effort.

____

Signature of Certifying Professional   Today's Date

Please print all the following information

Professional's Name and Title: ____

Professional's License Number: ____

Professional's Physical Address: ____

Professional's Telephone Number: ____

Professional's Fax Number: ____

Is the student currently under your care? ☐ Yes ☐ No

If yes, for how long (length of care)? ____________________

Do you have a DSM-V diagnosis for this student? ☐ Yes ☐ No

If so, what is it? ____________________

____

Date of above DSM-V diagnosis (month, day, year): ____________________

Date student was last seen (month, day, year): ____________________

In addition to DSM-V criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.

Criteria	**Additional Notes**
☐ Structured or unstructured interviews with the student	
☐ Interviews with other persons	
☐ Behavioral observations	
☐ Developmental history	
☐ Educational history	
☐ Medical history	
☐ Neuro-psychological testing. Date(s) of testing:	
☐ Psycho-education testing. Date(s) of testing:	
☐ Standardized or non-standardized rating scales	

Please check which of the major life activities listed below are affected because of the psychological diagnosis. Please indicate the level of limitation.

Life Activity	**No Impact**	**Moderate Impact**	**Substantial Limitation**	**Don't Know**
Concentrating	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Interacting with Others	☐	☐	☐	☐
Caring for oneself	☐	☐	☐	☐
Performing manual tasks	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Communicating	☐	☐	☐	☐
Working	☐	☐	☐	☐
Operation of a major bodily function (including but not limited to, functions of the immune system, special sense organs and skin, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, genitourinary, reproductive functions, or the operation of an individual organ within a body system.)	☐	☐	☐	☐
Other:	☐	☐	☐	☐

Is this student currently taking medication(s) for these symptoms? ☐ Yes ☐ No

Describe medication(s), date(s) prescribed, effect on academic functioning, and side effects.

____

____

Do limitations/symptoms persist even with medications? ☐ Yes ☐ No

What is the student's prognosis?

____

____

How long do you anticipate the student's academic achievement will be impacted by this disability?

☐ Six months ☐ One year ☐ More than one year

What other specific symptoms currently manifesting themselves might affect the student's academic performance?

____

____

Is there anything else you think we should know about the student's learning disability?

____

____