

**Office of Disability Services**

2500 North River Road | Manchester, NH 03106-1045 | Phone 603-645-9630 | Fax 603-645-9718

Guidelines for Documentation of Physical/Sensory Disability

Please check applicable disability(ies):

- Chronic Health Disorder \_\_\_\_\_
- Orthopedic Disorder (mobility disability) \_\_\_\_\_
- Visual Disorder (blind/low vision) \_\_\_\_\_
- Hearing Disorder (deaf/hard-of-hearing) \_\_\_\_\_
- Head Injury/Traumatic Brain Injury \_\_\_\_\_ (must include neuropsychology evaluation)

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**This form must be completed by the diagnosing professional.**

Eligibility requirements for support services for students with disabilities:

1. Student provides comprehensive documentation, including this form.
2. Student is assessed as having a functional limitation in the educational setting with evidence to establish a rationale to support the need for accommodations(s).

Please provide the following information about \_\_\_\_\_  
(Student's Name)

Permission for release of information to Southern New Hampshire University:

**Signature of Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Description of Disability: \_\_\_\_\_  
\_\_\_\_\_

2. Level of Severity (circle one)    Mild                    Moderate                    Severe

3. Date of Diagnosis: \_\_\_\_\_ Last contact with student: \_\_\_\_\_

4. Length and type of treatment: \_\_\_\_\_  
\_\_\_\_\_

5. Describe symptoms which meet the criteria for this diagnosis with approximate date of onset (*please attach diagnostic report*): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Describe this student's functional limitations in an educational setting.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Southern New Hampshire University

7. Have you any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level? *Describe services/accommodations in exam administration, classroom or study activities, or University requirements.*

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8. Provide current medication status related to this disability.

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9. Will treatment (medication/therapy) be required locally? \_\_\_\_\_  
If yes, have any arrangements been made for local care, and with whom?

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10. In addition to the diagnostic report (appropriate to specific disability), please attach other information relevant to this student's social and academic adjustment at Southern New Hampshire University.

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Signature of Diagnosing Professional: \_\_\_\_\_

Print name and title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

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**Please return this information to:**

Office of Disability Services  
Southern New Hampshire University  
2500 North River Road  
Manchester, NH 03106-1045  
**Phone:** 603-668-2211  
**Fax:** 603-645-9718  
**Attention:** Hyla Jaffe, Lisa Levy, or Liz Henley

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