WESTERN NEW ENGLAND UNIVERSITY | WNE

STUDENT DISABILITY SERVICES

RELEASE OF INFORMATION & DISABILITY CERTIFICATION FORM

The student listed below is seeking disability-related accommodations at Western New England University (WNE). In order to establish eligibility, the student must substantiate a disability by providing information about the nature and impact that the disability has on one or more major life activities and specifically within a university setting. Some examples of a major life activity include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Students whose conditions create a substantial limitation to a major life activity may qualify to receive accommodations on the basis of their disability.

****

Student completes this section:

By signing below, the student authorizes the clinician or qualified evaluator listed here to release information about the nature and impact that their disability has on a major life activity within an educational setting to Western New England University Student Disability Services (SDS). SDS holds this information in strictest confidence.

Please Print:

Student Name: _____ WNE ID:_____

Clinician Name: _____

Student Signature: _____ Date: _____

****

The licensed clinician or qualified evaluator who is working with this student for the diagnosis identified in this document must complete this section.

Diagnosis (include diagnostic code):

Please indicate the level of severity:

☐ Mild ☐ Moderate ☐ Severe

Date of onset: _____ Date of last office visit: _____

Please describe the procedures used to establish the diagnosis:

Please attach any additional information that may support this student's eligibility for accommodations as appropriate (i.e. diagnostic reports).

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Expected duration of disability/impairment:

☐ Permanent/chronic ☐ Short-term: 1-3 months ☐ Long-term: 3 - 12 months

☐ Temporary: <1 month – Please indicate anticipated date of recovery: _____

Describe the functional limitations and impact to a major life activity. Specifically address how the functional limitations may impact coursework and other activities in an educational setting.

Discuss any impact that side effects may have with regard to any treatment plan or medications.

Do you have recommendations (must be directly linked to the functional limitations resulting from the disability/impairment) for accommodations in a university environment?

State Licensure/Certification #: _____

Professional Title: _____

Name of Agency/Institution: _____

Mailing Address: _____

_____

Telephone Number: _____

Clinician's Signature: _____ **Date:**_____

Please forward this form and any corresponding documentation to:

SDS | Western New England University |1215 Wilbraham Road | Springfield, MA 01119

Tel: 413-782-1258 | Fax: 413-782-1575