RELEASE OF INFORMATION & DISABILITY CERTIFICATION FORM

The student listed below is seeking accommodations at Western New England University on the basis of a disability. A disability is defined by the Americans with Disabilities Act as a physical or mental impairment that *substantially limits* one or more major life activity, having a record of, or being regarded as having a disability. Examples of a major life activity include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

SDS is the office on campus responsible for determining eligibility for accommodations and subsequently those accommodations that would be reasonable in a university environment. Accommodations are determined on an individualized case-by-case basis and must be directly linked to the impact a condition may demonstrate.

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 condition may have on a major life activity. SDS holds this information in strictest confidence.

<table>
<thead>
<tr>
<th>Please Print:</th>
</tr>
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<tbody>
<tr>
<td>Student Name: ___________________________________ WNE ID:______________</td>
</tr>
<tr>
<td>Clinician Name: ___________________________________</td>
</tr>
</tbody>
</table>

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 whenever possible):

Please indicate the level of severity, if applicable:

☐ Mild  ☐ Moderate  ☐ Severe

Date of onset: ______________________ Date of last office visit: ______________________
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Expected duration of disability/impairment, if known:

☐ Permanent/chronic  ☐ Short-term: 1-3 months  ☐ Long-term: 3 - 12 months
☐ Temporary: <1 month – Please indicate anticipated date of recovery: ________________

Frequency and duration of symptoms, if relevant:

☐ Daily  ☐ 1/week  ☐ 1-3/week  ☐ 1/month  ☐ 1-3/year  ☐ Seasonal
☐ None – symptoms under control with medication  ☐ Other: __________________________

Please describe how the condition impacts one or more major life activity and the need for accommodation in an educational setting.

Please attach any additional relevant information (i.e. diagnostic evaluation) to explain the impact of the student’s condition on their functioning.

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