Resource Center for Persons with Disabilities (RCPD)

Maximizing Ability & Opportunity

Michigan State University

434 Farm Lane #120 Bessey Hall

East Lansing, MI 48824-1033

Phone: (517) 884-RCPD Fax: (517) 432-3191

rcpd.msu.edu



**DISABILITY DOCUMENTATION FORM:**

**autism spectrum disorders**

# PLEASE REVIEW CAREFULLY

The individual named below has applied for services from the Resource Center for Persons with Disabilities (RCPD) at Michigan State University. Michigan State University provides academic and workplace services and accommodations to individuals with disabilities. Individuals seeking services must provide appropriate medical documentation of their condition so that the RCPD can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

*The Americans with Disabilities Act (ADA) defines disability as “a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment.” Disabilities involve ongoing substantial limitations and are distinct from temporary or common conditions not substantially limiting major life activities.*

**Documentation required to verify the condition, severity, and functional limitations includes completion of this form or provision of equivalent information to the RCPD by a licensed mental health professional.** Depending on the condition, the appropriate professional should be a licensed psychiatrist, psychologist, neurophysiologist, or other qualified and licensed mental health professional. Professionals completing this form must have first-hand knowledge of the condition, experience in working with students and employees with autism spectrum disorders and ideally a familiarity with the physical, emotional and cognitive demands experienced by students and employees in an academic setting. Diagnoses of disabilities documented by family members are unacceptable. For additional information regarding documentation guidelines, refer to the **Educational Testing Services** (ETS) guidelines at [www.ets.org](http://www.ets.org) or [www.eeoc.gov](http://www.eeoc.gov).

“The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”

**Client name**: Last, First, Middle Initial

**Date of Birth:** **Client’s MSU NetID**:

**Certifying Professional’s Printed Name:**

**Credentials/Specialization:**

**License Type:**

**License #: State: Exp. Date:**

Mailing Address:

**City/State/Zip:**

**Phone:** **Fax**:

**Email:**

|  |  |
| --- | --- |
| |  | | --- | | Attach Business Card Here  or  If Submitting Electronically,  Denote your Office Web Address | |

**Office web address:**

**Diagnosis/Diagnoses**: Please include **DSM or ICD Codes** and **name of condition(s)**

Date of onset: Date of diagnosis:

**Diagnostic Tools:** How did you arrive at your diagnosis/diagnoses? Please check any relevant items below:

|  |  |
| --- | --- |
| Interviews with the client | Interviews with other persons |
| Behavioral observations | Developmental history |
| Medical history | Neuro-psychological testing |
| Psycho-educational testing | Self-rated or interviewer rated scales |
| Other | |

**Prognosis**

**Expected Duration of Primary Condition: (Check One)**

Permanent (check Permanent for conditions of 6 months or more with expected duration into the foreseeable future)

Temporary (include expected duration and rationale for temporary status)

**Characteristics of Limiting Condition(s): (Check All That Apply)**

Stable Episodic Slow Progression Rapid Progression Improving

Additional comments/information

**Medication, Treatment, and Prescribed Aids**

What medication(s) are currently being used to address the diagnosis/diagnoses above? For each prescribed medication, describe side-effects that may adversely affect the client’s academic or workplace performance.

Who is prescribing medication (include name and contact information) if different than professional completing this form:

What treatment and prescribed aids (i.e. counseling, therapy, support groups) are currently being used to address the diagnosis/diagnoses above?

Who is prescribing this treatment and prescribed aids (include name and contact information) if different than professional completing this form:

Is the client compliant with medication and prescribed aids as part of the treatment plan? If no, please explain:

Date of last appointment:

How often does your client receive treatment?

Weekly Monthly Annually As needed

**Implications for Workplace or Academic/Student Life**

Disabilities involve ongoing substantial limitations and are distinct from temporary or common conditions not substantially limiting major life activities.

The Americans with Disabilities Act (ADA) defines disability as *“a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment.”*

Identify below any functional limitations/restrictions that remain and impact major life activities even with the treatment listed previously.

|  |  |  |  |
| --- | --- | --- | --- |
| **Major Life Activity** | **Impacts**  Please check the severity of impacts | **Frequency of Impact to Major Life Activity** | **Explanation of Impact**  Please describe how your client’s condition impacts each major life activity and include examples relating to workplace or academic/student life. |
| Concentration | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Long Term Memory | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Short Term Memory | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Sleeping | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Eating | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Listening | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Social Interactions | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Self-Care | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Managing Internal Distractions | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Managing External Distractions | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Time Management | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Motivation | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Stress Management | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Organization | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Communication | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Other (Explain):  \_\_\_\_\_\_\_\_\_\_\_\_ | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |
| Other (Explain):  \_\_\_\_\_\_\_\_\_\_\_\_\_ | None  Moderate  Substantial  Unsure | Hourly  Daily  Weekly  Monthly |  |

Please print this documentation, sign and date below. Send or fax directly to RCPD using the contact information on page one.

**Date:**

**Certifying Professional’s Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document.**

**Additional/Secondary Certifying Professional’s Signature (if applicable):**

**My Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document.**