ACCESSIBILITY RESOURCES
MINNESOTA STATE UNIVERSITY, MANKATO

Support for Students with Disabilities.

132 Memorial Library • Mankato, MN 56001
507-389-2825 (Phone) • 800-627-3529 (MRS/TTY) • 507-389-1199 (Fax)
www.mnsu.edu/access

DOCUMENTATION OF DISABILITY

Accessibility Resources' goal is to provide reasonable and effective accommodations for students with qualifying disabilities, to support equal access to their education.

Eligibility for accommodations is determined by the individual's qualifications as a person with a disability. A disability is a physical or mental impairment that substantially impairs or restricts one or more major life activities. Documentation must be less than three years old.

Student Name: ___________________________________**Tech ID#**_______________

Address: ____
____

Initial Diagnosis Date: ____

Most Recent Assessment Date: ____

Disability/Diagnosis: ____
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____
____

The diagnosis must clearly state a DSM-V Diagnosis and must verify interference with a major life activity. Please check the major life activities affected by the above listed diagnosis:

___Caring for oneself ___ Hearing
___Performing manual tasks ___ Breathing
___Walking ___ Learning
___Seeing ___ Working

Current Symptoms:
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____
____
____

Current Treatment Strategies and Prognosis:

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____

Summary of the functional limitations of the disability and the impact of medication and/or treatment on educational functioning:

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Suggested Accommodations:

Health Providers can provide suggestions for reasonable accommodations appropriate at the post-secondary level of education. Such accommodations should be supported by the assessment results and by the diagnosis. Accessibility Resources will evaluate recommendations on a case-by-case basis. Accommodations must be reasonable and cannot fundamentally alter the basic nature or essential elements of an institutions/s courses or programs.

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Provider's Name: ____

Provider's Title/Credentials: ______________________________________

Provider's Signature: ____

Provider's/Clinic's Phone Number: ________________________________

Date: ____

Please return the form to Accessibility Resources at the fax number listed above.

It is imperative we receive verification of the provider's authenticity. All documentation must include an official clinic stamp, original letterhead and/or fax cover sheet.