



Disability Determination Form

Dear Healthcare Professional:

Your patient/client, _____, wishes to receive accommodation at *Princeton Theological Seminary*. The Accessibility Services office provides academic accommodations for students with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973 and with the Americans with Disabilities Act (ADA) of 1990 as amended in 2008. The ADA states the following:

The term “disability” means with respect to an individual –

- A. A physical or mental impairment that substantially limits one or more major life activities of such individual;
- B. A record of such an impairment; or
- C. Being regarded as having such an impairment.

For a student to be considered eligible to receive academic accommodation, documentation must show functional limitations that impact the individual in an academic setting. Individuals requesting accommodations must disclose the nature of their impairment and provide recent documentation that verifies their condition. When providing information necessary to evaluate eligibility for academic accommodations, please adhere to the following:

- **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These professionals are generally trained, certified, or licensed psychologists or members of a medical specialty.
- **Complete the attached form as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting may delay the eligibility review process by necessitating follow-up contact for clarification. This form can also be completed by typing information into the fillable PDF form.
- **The healthcare professional should attach any reports that provide related information (e.g. psycho-educational testing, neuropsychological test results, medical evaluation results, etc.).** If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Please do not provide case notes or rating scales without a narrative that explains the results.
- **After completing the attached form, sign it and complete the Healthcare Provider Information section on the last page. The completed form can be emailed as a PDF to academic.support@ptsem.edu or faxed to 609-497-7819.** The information provided will be forwarded to the Accessibility Services Specialist where it will be held strictly confidential. This form may be released to the student at their request. In addition to the requested information, please attach any additional information that would be relevant to the student’s academic adjustment.

If you have questions regarding this form or the Accessibility Services process, please email, academic.support@ptsem.edu or call 609-497-7737. Thank you for your assistance.

DISABILITY DETERMINATION FORM

Student Information (Please Print Legibly or Type)

Name (Last, First, Middle): _____

Date of Birth: _____

Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Address (Street, City, State, Zip Code): _____

To Be Completed by Healthcare Professional

Date last seen: _____

Impairment/Diagnosis(s) (If applicable, include date of diagnosis and DSM-6/ICD-10 codes):

Relevant patient/client history:

Additional psychosocial and contextual factors:

How was the impairment/diagnosis determined?

☐ Structured or unstructured interviews with the student

☐ Interviews with other people

☐ Behavioral observation

☐ Developmental History

☐ Educational History

☐ Medical History

☐ Neuropsychological testing (dates of testing) _____

☐ Psycho-educational testing (dates of testing) _____

☐ Standardized or non-standardized rating scale

☐ Other (please specify)

How would you categorize this condition in terms of severity? Please check only one and explain below.

☐ Minimal ☐ Moderate ☐ Severe ☐ Residual/Remission ☐ Other: _____

The condition is: ☐ Stable ☐ Prone to exacerbation ☐ Other: _____

Duration of impairment/diagnosis is: ☐ Permanent ☐ Temporary

Note Duration: _____ **or** Re-Evaluation Date: _____

Indicate major life activities that are affected because of the impairment and severity of those limitations.
This list is not exhaustive and additional life activities can be added at the bottom of this chart.

Life Activity	Negligible	Moderate	Substantial	Don't Know	N/A
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping Appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing External Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Internal Distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Studying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specifically describe to what extent the impairment impacts the student's ability to function academically and in an academic setting addressing any items endorsed on the previous page:

If applicable, list any medications currently prescribed and how they have an impact on the student's learning. Please also include any side effects and impact on academic performance:

Is this student currently receiving therapy or counseling? ☐ Yes ☐ No ☐ Not Sure

Please indicate specific recommendations regarding academic accommodations for this student and a rationale as to why these accommodations/adjustments/services are warranted based on the student's functional limitations. Indicate why the accommodations are necessary.

If current treatments (e.g., medication, therapy) are successful, please state the reason that the above academic adjustments, auxiliary aids, and/or services are necessary.

With reasonable accommodations, do you feel the student is capable of taking a full course load of 9 graduate credits?

☐ Yes ☐ No (Please explain below)

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.

Healthcare Professional Signature: _____ Date: _____

Healthcare Professional Name (Print): _____

Title: _____

License or Certification #: _____

Address: _____

Phone: () - Fax Number: () -

Email Address: _____

Name of Person Completing Form: _____ Date: _____

Professional Affiliation/Title: _____