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Office of Disability Services
APPALACHIAN STATE UNIVERSITY

Disability Documentation Guidelines

In order to establish that an individual is covered under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, the following materials are generally needed:

1. Disability Disclosure Form: (to be completed by person requesting accommodations); and
2. Current documentation prepared by a professional relevant to the requested accommodations; and
3. If applicable, historical use of accommodations via IEPs, SOPs, 504s or other previous approvals.

Insufficient Documentation

ODS does not interpret a diagnosis, the current impact and/or functional limitations from documentation, therefore, the following materials alone are generally not sufficient for determining eligibility:

- official medical records, medical chart notes or prescription pad notations;
- high school IEPs, 504 Plans and/or SOPS not accompanied by disability documentation;
- documents prepared for specific non-educational venues (i.e., Social Security Administration, Department of Veteran's Affairs, etc.).

Documentation Guidelines

Documentation must reflect the condition substantially limits a major life activity or major bodily function. ODS utilizes flexibility and discretion in determining how recent documentation must be, especially for conditions that are permanent or non-varying. Changing conditions and/or changes in how a condition impacts the individual may warrant more frequent updates.

Generally sufficient documentation includes: a psychological/psycho-educational evaluation or a letter from medical/mental health provider which includes the below numbered items.

1. Qualifications of Clinician/Provider: Documentation must be typed on office or practice letterhead, dated and signed by a professional who is licensed or certified in the area for which the diagnosis is made. Name, title, and license/certification credentials must be stated and shall not be family members or others with a close personal relationship to the individual.

2. Diagnosis & History: A diagnostic statement identifying the disability including ICD or DSM classification along with any relevant personal, psychosocial, medical, developmental and/or educational history.

3. Description of Diagnostic Methodology: A full description of the diagnostic methodology used, including data and measurements from appropriate evaluation instruments. The results obtained should draw a direct link to the diagnosis and the functional limitations of the disability. For cognitive disorders, evaluations should use adult norms.

4. Current Impact and Functional Limitations: A clear description of the current impact and functional limitations of the condition pertaining to the academic, workplace and/or residential settings. Information regarding if symptoms are constant or episodic, and the frequency and/or duration should be addressed. Any treatments, medications, and/or assistive devices/services currently prescribed or in use, should include a description of the mediating effects and potential side effects from such treatments.

5. Recommendations: Recommendations should be directly linked to the impact or functional limitations associated with the disability, or medication prescribed to control symptoms and include a clear rationale based on level of impairment.