Johns Hopkins University
Student Disability Services
Documentation Form

Please note: A clinician with relevant expertise and who is not related to the student should complete this form.

In order for us to provide disability-related services and accommodation, we need to establish that this individual has a physical or mental impairment that limits one or more of the major life activities, understand the impact of that disability in higher education settings, and determine reasonable accommodations and services that may assist in ameliorating these impacts. Complete documentation guidelines are available at: https://sds.jhu.edu/requesting-accommodations/documentation-guidelines/

Date: ____________________  Student Status:

________________________

☐ Undergraduate
☐ Graduate
☐ Medical
☐ Other: __________________

Individual's Name

________________________

JHU School

Diagnosis (if known)/Description of the Functional Impact (required)

1. Please state the condition/diagnosis:

2. How did you arrive at your diagnosis? Please check all relevant items below:
   ☐ Structured or Unstructured interview  ☐ Medical tests
   ☐ Interviews with others  ☐ Medical History
   ☐ Behavioral Observations  ☐ Developmental History

3. Describe the relevant, current impact of the condition on the student in a higher education setting (academic, housing, dining, transportation, social, etc).
History and Prognosis (to the degree known)

Date condition was first diagnosed: ____________________________________________

Date individual first seen for the condition: ______________________________________

Date most recently seen for this condition: _______________________________________

Expected duration of condition: ________________________________________________

Anticipated return to work/school date: _________________________________________

The condition is:

☐ Stable  ☐ Improving  ☐ Worsening  ☐ Variable  ☐ Other:__________

The prognosis is:

☐ Poor  ☐ Fair  ☐ Good  ☐ Improving  ☐ Other:__________

How often is this individual seen?

☐ Weekly  ☐ Monthly  ☐ 3-6 months  ☐ Yearly  ☐ Other: __________

4. If the individual is currently taking medication that has side effects and any impact on functioning, please describe below. Do limitations/symptoms persist even with medications?

| blank space for medication description |

5. Please list any specific accommodations or services recommended to address the functional limitations identified.

| blank space for accommodations or services |

6. Do you anticipate any changes in the individual’s condition/treatment?

☐ No  ☐ Yes  Please explain.

| blank space for anticipated changes explanation |
7. Is the individual working with another physician or specialist to treat the condition(s)?
   □ No    □ Yes  Please explain and indicate who else if known.

8. Is there anything else you think we should know about the individual or their condition?

PLEASE TYPE OR PRINT CLEARLY

________________________________________
Name, Title

________________________________________
Signature

________________________________________
Date

________________________________________
License/Certification #

________________________________________
State

Address

________________________________________
Phone

________________________________________
Fax

Additional information can be submitted in a signed, typewritten letter on letterhead.

Documentation should be uploaded into the AIM database by the student after an initial application is submitted or provided to the SDS staff member at the respective school.

Edited October 2023