# Disability Documentation Form for Division of Extension

The University of Wisconsin-Madison provides accommodations for individuals with disability participating in programs and events through the Division of Extension. Participants are required to provide documentation that verifies that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for accommodations is based on documentation that clearly demonstrates an individual has one or more functional limitations in a major life activity directly related to the program or event in which they are seeking to participate.

As this individual’s treating clinician/specialist, you are asked to provide the following information to allow the university and the Division of Extension to consider this client’s request(s).

**Please complete the following:**

1. **Participant Information:**

|  |  |
| --- | --- |
| Client Name: |  |
| Preferred Name: |  |
| Date of Birth (mm/dd/yyyy): |  |

1. **Diagnosis:**

|  |  |
| --- | --- |
| What is the diagnosis? |  |
| Date of original diagnosis: |  |
| Is the condition temporary (< 6 months) or persistent? |  |

1. **Functional Impact Assessment (REQUIRED)**

**Please check the diagnosis’ impact on major daily life activities to the best of your knowledge. Check all that apply**

|  |  |  |  |
| --- | --- | --- | --- |
| Caring for Oneself | Talking | Hearing | Breathing |
| Seeing- Close or Long Distance | Lifting/Carrying | Sitting | Performing Manual Tasks |
| Eating | Sleeping | Standing/Walking | Interacting with Others |
| Learning | Reading | Writing | Memorizing |
| Concentrating | Speaking | Bodily Functions | Other: |

1. **For any of the major daily life activities checked above, please list it in the box below, and rate the frequency or duration of impact (i.e. rare, intermittent, frequent/daily, or chronic).**

|  |
| --- |
|  |

1. **Please list your recommendations and rationale for accommodations.**

| Accommodation Recommendation | Rationale |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

1. **Certifier Information:**

|  |  |
| --- | --- |
| Clinician Name (print) |  |
| Clinician Name (signature) |  |
| License |  |
| Address |  |
| Phone |  |
| Email |  |
| Date |  |

Please send this completed form and any additional documentation to:

McBurney Disability Resource Center, Attn: Heather Stelljes, 702 W. Johnson Street, Ste. 2014,

Madison, WI 53715

Phone: (608) 263-2741 Text: (608) 225-7956 Fax: (608) 265-2998

(email) heather.stelljes@wisc.edu

If you have questions, please feel free to contact our office. Thank you.