

GOUCHER COLLEGE

**Disability Documentation Form for Students Requesting Assistance Animals in the Residence Halls
To Be Completed By Student's Health Care Provider**

Goucher College is deeply committed to the full participation of students with disabilities in all aspects of College life. In accordance with section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA), Goucher College has established procedures to ensure that students with documented disabilities are reasonably accommodated in Goucher program activities.

Student Name: _____

By my signature, I give my consent for Goucher College's Office of Accessibility Services (OAS) to contact my healthcare provider for additional information as needed, and further give my consent to my healthcare provider to discuss my situation with the Office of Accessibility Services (OAS) and/or the Goucher Health and Counseling Centers.

Student Signature: _____

Name and Credentials of the Provider Making the Recommendation: _____

The student named above has requested an accommodation from Goucher College because of a disability. A disability is defined under the Americans with Disabilities Act as a "physical or mental impairment that substantially limits one or more major life activities." Examples of major life activities are: seeing, hearing, speaking, breathing, eating, sleeping, walking, standing, lifting, bending, learning, reading, communication, working, performing manual tasks, caring for oneself, thinking, concentrating, and the operation of major bodily functions. A temporary impairment may include an injury, severe illness, recovery from surgery, or a condition caused by a traumatic event.

1. Based on this definition, does this individual have a disability or temporary impairment? YES NO
2. If yes, please cite the student's disability(ies) or impairment(s) (use additional space if needed) :

The code for this is _____ from the DSM-IV-TR DSM-V ICD-9 ICD-10

3. Date of diagnosis: _____ Made by you? If not, by whom? _____
4. Date of most recent evaluation: _____
5. Currently under your care? _____

I certify that I am competent to make an assessment regarding the assistive and/or therapeutic benefits of assistance animals for people with disabilities such as that experienced by the student identified above.

Health Care Provider's Contact Information (Stamp or Write):

Office Address: _____

Email: _____ Phone Number: _____

Signature: _____

Date: _____