



**Office of Disability Services**

The University of North Carolina at Charlotte  
9201 University City Boulevard, Charlotte, N.C. 28223-0001

**Office of Disability Services Documentation Form**

**Student Name:** \_\_\_\_\_ **Student ID:** \_\_\_\_\_  
(Last First MI)

**IMPORTANT:** The Americans with Disabilities Amendment Act defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Thorough completion of this form is necessary for Disability Services to determine eligibility for accommodations. Insufficient information may result in ineligibility. *Complete one documentation form for each diagnosis or condition.* Please note the following information:

- Any record provided to Disability Services becomes part of the student’s “education record” pursuant to the Family Educational Rights and Privacy Act (FERPA). Under the privacy protections and access provisions of FERPA, the student has the right to inspect his or her own education records if requested.
- A learning disability diagnosis must be accompanied by a current, appropriate psycho-educational evaluation, including the diagnostic test scores.
- Visual or hearing loss documentation must include an acuity and/or audiology report that addresses the current impact of the disability, as well as information about the specific assistive technology used by the student.
- Housing or dietary accommodations require additional completion of the *Housing Addendum Form*.

---

**TO BE COMPLETED BY DIAGNOSTICIAN OR TREATING PROFESSIONAL**

Date of birth: \_\_\_\_\_

DSM-V or ICD diagnosis: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_ Date of most recent office visit: \_\_\_\_\_

Does this disorder substantially limit the student?  **Yes**  **No**

Attach any supporting documentation: e.g., psycho-educational evaluations for learning disabilities, audiology reports, vision reports, etc.  **Supporting documentation attached**

Describe the student’s condition, symptoms, and the impact on life activities, including academics:

---

---

---

---

Treatments, medications, assistive devices/services currently prescribed or in use:

---

---

Will medication adversely impact this student, if so how?

---

---

Expected duration of the impact of the disability:

- Temporary - Indicate anticipated recovery date: \_\_\_\_\_
- Permanent
- Chronic
- Episodic/Recurring

Expected progression or stability of the impact of the disability:

---

Recommended accommodations related to disability, including those used in the past:

---

---

---

Name of Diagnostician/Professional: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License #: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Please attach a copy of your business card and submit the accompanying report to:**

**Office of Disability Services  
UNC Charlotte  
Fretwell 230  
9201 University City Boulevard  
Charlotte, NC 28223-0001  
Email: [disability@uncc.edu](mailto:disability@uncc.edu)  
Fax: (704) 687-1395  
Voice/TDD: (704) 687-0040**