



## **Guidelines for Documentation of Physical Disabilities and Chronic Health Conditions**

Physical disabilities is a generic term that can refer to a variety of conditions of short or long duration. Physical disabilities include but are not limited to impairments, chronic illnesses, traumatic brain injury, arthritis, and visual, hearing, mobility, and manual limitations.

Major life activity: Examples of major life activities include walking, sitting, standing, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks.  
Current functional limitation: A substantial impairment in a student's ability to function with respect to the condition, manner, or duration of a required major life activity.

### **Documentation Requirements**

#### **I. A qualified professional must conduct the evaluation**

Qualified evaluators are defined as those licensed individuals who are qualified to evaluate and diagnose physical disabilities or who may serve as members of a diagnostic team. These individuals or team members may include physicians, nurse practitioners, surgeons, dentists, optometrists, audiologists, physical therapists, occupational therapists, neuropsychologists, and other relevantly trained healthcare professionals qualified to make such diagnoses. Diagnoses of physical disabilities documented by family members will not be accepted.

The name, title, and credentials of the qualified professional writing the report should be included. Information about licensure or certification, including the area of specialization and employment, should also be clearly stated in the documentation. All reports should be in English, typed on professional letterhead, dated, and signed.

#### **II. Documentation must be current**

The documentation must address the student's current level of functioning and the need for accommodations (e.g., due to observed changes in performance or medication changes since previous assessment). If the diagnostic report is more than six months old, the student should also submit a letter from a qualified professional that provides an update of the diagnosis, a description of the student's current level of functioning during the preceding six months, and a rationale for each of the requested testing accommodations.

#### **III. Documentation necessary to support the diagnosis must be comprehensive**

Documentation should be based on a comprehensive diagnostic/clinical evaluation that adheres to the guidelines outlined in this document. In addition to a history of presenting symptoms, date of onset, duration and severity of the disorder, and relevant developmental and historical data, the diagnostic report should include the following components:

- A. Specific diagnosis  
Clinicians should cite the specific objective measures used to help substantiate diagnoses. The evaluator should use definitive language in the diagnosis of a physical disability, avoiding such speculative language as "suggests," "has problems with," or "could have problems."
- B. Current functional limitations in the academic environment  
A description of current functional limitations in the educational environments, as well as across other settings, with the understanding that a physical disability usually presents itself across a variety of settings other than just the academic domain. The description should include medical information describing the degree to which the current functional limitations restrict the condition, manner, or duration under which the student can perform a major life activity as compared to the average person in the general population.

- C. Medical information  
Relevant information regarding any medications that may impact educational performance. Given that many students benefit from prescribed medications and therapies, a positive response to medication in and of itself does not confirm a diagnosis, nor does the use of medication in and of itself either support or negate the need for accommodations.
- D. Relevant information regarding treatment  
Relevant information regarding current treatment for this or any other conditions, and the degree of impact on educational performance.
- E. Alternative explanations  
Evidence that alternative etiologies or explanations have been considered in a differential diagnosis and ruled in or out as appropriate. Such alternative explanations include substance abuse; medication effects; psychiatric, learning, and attentional disorders; and motivational factors affecting performance/functioning.
- F. A rationale  
A rationale for each accommodation requested. The clinician must describe the degree of impact of the disorder on a specific major life activity, as well as the degree of impact on the student. A link must be established between the requested accommodations and the functional limitations of the student that are pertinent to the educational environment. For example, it may be that extra rest breaks or longer rest breaks would better accommodate a given disability than would additional testing time.

Note that a diagnosis in and of itself does not automatically warrant approval of requested accommodations. For example, although migraine headaches can be very painful and distressing, the mere anticipation that one is going to have a migraine is not a disability.

Please note, if the director of Academic Advisement deems the documentation to be inadequate in scope or content, a reevaluation may be required before accommodations will be provided.

*Adapted from the Educational Testing Service (2003)*

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