Medical and Mobility (Systemic/Visual) Disorders
Instructions and Documentation Submission Form

Student Instructions and Information:

1. Students must submit medical documentation of a Medical and Mobility (Systemic/Visual) Disorder from a qualified provider (medical doctor or psychiatrist) to the Access & Accommodations Center (AACE). You may do so by having your qualified provider complete this Form or by submitting a letter from a qualified provider that includes all of the information requested in this form. Letters from qualified providers must be on letterhead from the provider's practice and must include the provider's signature and credentials.
2. Documentation of a Medical and Mobility (Systemic/Visual) Disorder must be **current**. Less recent documentation may be submitted for review but may not be accepted if it fails to adequately indicate current functioning.
3. Students should submit the required medical documentation **prior to the initial meeting with AACE** if possible since appropriate accommodations are discussed at that time.
4. How often medical documentation must be updated will be determined by AACE based on the student's individual situation.
5. Documentation may be submitted through the AIM portal at https://access.gsu.edu/

To be Completed by Student:

Name (Last, First, Middle):____

Date of Birth: ______________________________ GSU ID: _________________________

Cell Phone: ______________________________ Alternate Phone: _______________________________

Home Address: ____

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Email Address: ____

Status (Check One): ____Current Student ____ Transfer Student ____ Prospective Student

To be Completed by Provider:

To establish eligibility for accommodations under the ADA, students must submit current and comprehensive medical documentation from a qualified provider for any diagnosis of a disability. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

Primary Diagnosis: ____

DSM-5/ICD-10 Code: _________________________________Date of Diagnosis: ____________________

Secondary Diagnosis: ____

DSM-5/ICD-10 Code: _________________________________Date of Diagnosis: ____________________

Please provide the diagnostic criteria and methodology used to diagnose the condition.

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Please describe the history and severity of the disorder.

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Is it expected that the patient's functioning and/or severity of the disorder will change over time?

_____Yes _____No

If yes, please explain the anticipated progression.

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Please check all of the following as appropriate to describe the patient's functional limitations.

______Use of a wheelchair or scooter to aid mobility
______Limited stamina
______Fatigue
______Headaches accompanied by nausea, vomiting, and/or sensitivity to light and sound
______Limited upper body mobility, trouble grasping, handling objects
______Lack of muscle control and balance
______Poor coordination
______Limited ability or unable to write/keyboard
______Affected speech
______Bowel and/or bladder incontinence
______Pain
______Low tolerance for temperature changes/extremes
______Problems being exposed to fumes/dust/mold/gasses, etc.
______Trouble with focus and concentration
______Breathing difficulties
______Problems with depression or mood swings
______Difficulty reading
______Limited space, form, and/or depth perception
______Field of vision deficit
______Medication side effects____
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______Other____
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______Other____
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______Other____
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Please provide any additional information/context as appropriate concerning the functional limitations.

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Please provide any recommendations to address the indicated functional limitations.

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Please attach any psychological and/or educational reports that support the diagnosis and associated functional impact and complete the following information:

Provider Name:____

Title:____

License #:____

Practice Name and Address:____

Phone:___________________________________Fax:_________________________________

Email:____

Provider Signature **(Wet Signature Required)**:____

Date of Signature:____