This form documents your self-disclosure of your disability and your request(s) for academic accommodations. This information is kept confidential at the highest level possible.

Name: ___________________________________ Class ______________
Email: ____________________________ Phone: ______________________
Disability disclosed:

Classroom/Testing Accommodation(s) requested:

Signature: ____________________________ Date: ______________

Please submit this completed form along with relevant documentation to the Disability Services office by uploading to the student portal, or via email or fax.

The attached healthcare form may be used as documentation. It should be completed by a licensed clinician familiar with the assessment of the student’s disability, functional limitations due to the disability, and accommodation needs.

Other documentation, such as a neuropsychological evaluation and previous educational accommodations may also be helpful in determining accommodation needs.
-Healthcare Documentation for Accommodation Request-
To be completed by a Licensed Medical Physician, Clinician or Therapist.

Student Name: ________________________________    DOB: ______________

The above person is a current or entering student at Wellesley College and is requesting accommodations on the basis of medical/mental health diagnosis(es). Please respond to the following questions regarding the student’s diagnosis in order to assist Wellesley College in our response to this request.

Is the student currently under your care?  ☐ Yes    ☐ No

If yes, for how long have you cared for this student? ______________________________________________________________________

Date of most recent treatment/contact: ______________________________________________________________________

Diagnosis _________________________________________________________________________________________________

_______________________________________________________________________________________________

Date of diagnosis ___________________    Duration of diagnosis ________________________________

Please describe any limitations the student has related to the diagnosis(es):
_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

List current medications and any side effects:
_______________________________________________________________________________________________

_______________________________________________________________________________________________
What circumstances might exacerbate the condition(s)?

________________________________________________________________________________
________________________________________________________________________________

What accommodations or other supports could be implemented to assist in minimizing or alleviating limitations?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Physician/ Clinician/Therapist Signature

_____________________________________

State license number

_______________________________

Specialty

______________________________

Date

_______________________________

Printed Name

Information may be forwarded to:

Office of Disability Services
Wellesley College
106 Central Street, Clapp 316
Wellesley, MA 02481

Phone: 781-283-2434
Fax: 781-283-3619
DisabilityServices@wellesley.edu

Office Address

City State Zip

Telephone

Fax

Please note: General notes or statements without a specific diagnosis history, severity level, limitations, signature, and appropriate provider credentials will not be accepted. Additionally, documentation statements from clinician parents/relatives will not be accepted.