Supplemental Documentation Form

The Disability Resource Center (DRC) at Portland State University collaborates with and empowers students with disabilities by working together proactively to determine reasonable accommodations. As part of the interactive process, the DRC may need documentation from students requesting reasonable accommodations.

The form below has been created as a courtesy for the Qualified Professional* to fill out. If preferred, the questions listed below could be addressed in a signed letter submitted on letterhead. Our documentation guidelines can also be downloaded from the DRC website if you have further questions.

Student information

Student's Name: PSU ID#:

Today's Date: Date of Birth:

Information from the Qualified Professional*

Please provide information about the student's current diagnosis(es) or condition(s).

Date of diagnosis: Date of last visit:

Please list the student's diagnosis(ses). Is the diagnosis permanent? If not, please state the expected duration of symptoms.

If the student is currently undergoing treatment or taking medication, are there any expected side effects of said treatment or medication? If so, please describe.

Please provide information about symptoms that, when active, affect the student's activities.

- ☐ Breathing
- ☐ Speaking
- ☐ Seeing
- ☐ Hearing
- ☐ Sleeping
- ☐ Eating
- ☐ Reading
- ☐ Learning
- ☐ Thinking/Concentrating
- ☐ Fine Motor Control
- ☐ Handwriting
- ☐ Lifting
- ☐ Walking/Climbing Stairs
- ☐ Standing
- ☐ Sitting
- ☐ Functioning of a Major Body Organ or Operation
- ☐ Fatigue
- ☐ Expressive/Receptive Skills
- ☐ Memory
- ☐ Interacting with Others
- ☐ Activities of Daily Living
- ☐ Managing Anxiety/ Stress
- ☐ Managing Distractions (Internal/External)
- ☐ Other

Describe the extent and nature of the above symptoms and their impact on activities of daily living and/or academic functioning.

Additional information or suggestions that may be helpful:

I am the Qualified Professional* responsible for determining the diagnosis and/or treating the student. The information provided is an accurate description of their diagnosis and functional limitations.

Date:

Signature of Qualified Professional*:

Printed Name:

Field of Practice:

License, Certification, Credential:

Address:

Telephone #: Fax #:

*Qualified Professionals must have knowledge or expertise in the differential diagnosis of the documented disability(ies) or condition(s) and follow established practices in the field.