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## The Carolina University Center for Teaching and Learning Accessibility Resources and Services

### DOCUMENTATION GUIDELINES

To establish that an individual is covered under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, documentation must be provided that indicates the disability substantially limits some major life activity, including learning.

It is the responsibility of the student to obtain the documentation and present a copy to the Center for Teaching and Learning (CTL). Any correspondence regarding the adequacy of the submitted documentation will be sent to the student. It is the student's responsibility to obtain additional information or clarification.

**Qualifications of the Examiner:** Documentation must be submitted by a professional who is licensed or certified in the area for which the diagnosis is made. Name, title and license or certification credentials must be stated in the documentation. The documentation should be on office or practice letterhead, dated, signed, and specifically addressed to CTL. The evaluating professional should not be related to the student.

### GENERAL DOCUMENTATION REQUIREMENTS

In general, the following information should be included in documentation submitted to CTL. Additional requirements specific to various disabilities are in the next section (“Required Documentation for Specific Medical Conditions or Disabilities”).

**History:** Personal, psycho-social, medical, developmental and/or educational history relevant to the cause for evaluation should be included. **NOTE:** CTL will not interpret a diagnosis and/or functional limitations from data included in official medical records.

**Specific Diagnosis:** The documentation must contain a clear, concise diagnostic statement which identifies the disability. The ICD and/or DSM classification must be included.

**Methodology:** A full description of the diagnostic methodology used, including all data and measurements from appropriate evaluation instruments, must be included. Data based evidence of disability and level of impairment is required for the provision of accommodations. A discussion of the methodology used, and the results obtained should draw a direct link to the diagnosis and the functional limitations of the disability. **NOTE:** Screening instruments, though

often used to support a diagnosis, are not sufficient indicators of impairment; they will not be used to determine specific accommodations.

**Current and Substantial Limitations:** Documentation should be age appropriate (within 3-5 years) and must include a clear description of current limitations imposed by the disability as they relate to classroom performance and the various demands of university life. The documentation should discuss evidence of the impact of the disability on actual academic performance, including any accommodations or related services the student has used. **Any impact, side effects or functional limitations observed or expected from the use of medication should also be discussed.** A discussion of the expected progress and/or stability of the disability should also be included.

**Differential Diagnosis and Co-Morbidity:** Documentation should include a discussion of assessment data that supports or refutes the diagnosis, including an exploration of alternative diagnoses as well as medical, psychiatric, educational, and cultural factors that may contribute to symptoms. If multiple diagnoses are provided documentation should indicate primary and secondary and should discuss the functional limitations associated with each.

**Recommendations:** Recommendations for accommodations should include a clear rationale based on level of impairment obtained from data based diagnostic evaluations and assessments. Suggestions for accommodations should be directly linked to the impact or functional limitations associated with the disability or medication prescribed to control symptoms. **NOTE:** The University will make final decisions concerning the appropriateness of accommodations.

#### REQUIRED DOCUMENTATION FOR SPECIFIC MEDICAL CONDITIONS OR DISABILITIES

In addition to the information provided by the general documentation requirements listed above, please provide the following information based on the specific nature of the medical condition or disability.

**Blind and Visually Impaired:** Documentation from an Ophthalmologist or Optometrist should include:

- specific diagnosis indicating current visual acuity
- near and distant vision (left and/or right)
- visual fields, with and without corrective lenses

**Chronic Medical Conditions:** The documentation should explain the current functional limitations imposed by the medical condition and should contain:

- specific diagnosis
- whether the limitations and/or symptoms are constant or episodic and the frequency and/or duration
- current medications and possible side effects
- any information that may assist in determining reasonable accommodations

**Cognitive Impairments:** Cognitive impairments may include Learning Disabilities (LD), Acquired Brain Injuries (ABI), Autism/Asperger’s Syndrome or attention deficit hyperactivity disorder (AD/HD). The documentation should explain the *current* functional limitations imposed by the condition, and should include the following:

- explanation of psychological and/or psycho-educational tests used; indicate all tests, data and/or scores used to support diagnosis
- current medications and possible side effects
- interviews, surveys, and other data collected to support diagnosis

**Deaf and Hard of Hearing:** The documentation should include a comprehensive audiologist’s report and should also include:

- a specific diagnosis
- date of onset (pre/post lingual)
- *current* hearing levels and whether hearing loss is stable or progressive
- speech reception levels with and without hearing aids and/or assistive listening devices

**Physical / Mobility impairments:** The documentation should identify functional limitations with respect to:

- gross or fine motor functioning
- the permanent or temporary nature of the of the condition (if temporary, expected duration of the limitation or impairment)

**Psychological/Psychiatric Conditions:** The documentation should explain the current functional limitations imposed by the condition. The following should be addressed:

- basis upon which an Axis I and/or an Axis II diagnosis was made
- If psychological and/or psycho-educational tests were used, indicate all tests, data and scores used to support diagnosis
- current medication including dosage and possible side effects
- short/long term prognosis
- therapeutic interventions and level of compliance
- educational implications and nature and severity of limitations

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## INSUFFICIENT DOCUMENTATION

In cases where documentation is incomplete students will be asked to provide additional or clarifying information from the evaluator. Students leaving the University for any reason may, upon readmission, be asked to submit updated documentation prior to receiving accommodations or services.

**Generally, the following documentation is NOT sufficient for the provision of services and accommodations:**

- High School IEPs, 504 Plans and/or SOPs
- documentation in which screening instruments or rating scales are used as the sole diagnostic tool
- official medical documentation, medical chart notes or prescription pad notations
- documentation that is not age appropriate (from last 3-5 years)
- testing instruments normed (standardized) for children rather than adults