

AMDA

College of the Performing Arts
NEW YORK CITY • LOS ANGELES

DISABILITY INFORMATION FORM

AMDA DISABILITY RESOURCE CENTER

Phone: (646) 823-5297

DRC@amda.edu

Disability Information Form

(to be completed by licensed medical professional only)

Student Last Name: _____ First Name: _____ MI: _____

Program Title: _____

Dear Provider,

The student named above is requesting accommodations with the Disability Resource Center at AMDA. This office provides reasonable academic and residential accommodations for students with documented disabilities. As part of the request process, students must disclose the nature of their disability and provide recent documentation that provides information about the impact of their disability. Thank you for your assistance in providing this information!

This section must be completed by the healthcare professional who is licensed to treat, and is treating, the student for the diagnosis listed below.

Does this student have a disability (physical or mental impairment that substantially limits one or more major life activities)? Yes ☐ No ☐

Specific diagnosis (if applicable, please include DSM-V code):

The above-referenced condition's effects are: ☐ Permanent ☐ Temporary (less than 120 days)

Expected duration is: _____ OR re-evaluation date is: _____

How was the diagnosis determined: _____

Please provide the prognosis (anticipated progression, duration, and stability) of the student's condition:

Are there any additional psychosocial or contextual factors you would like to mention?

Please review the following activities and check the ones which you feel are limited by the diagnosed disability and/or side effects from medications:

Activity	Mild	Moderate	Severe	N/A
Attending class				
Attention/Concentration				
Eating				
Fine Motor Dexterity				
Hearing				
Information Processing				
Memory				
Organization/Time Management				
Reasoning				
Self Care				
Situational Awareness				
Sleeping				
Social Interaction				
Stress Management				
Vision				

Please provide additional detail on the functional impact, especially for any activity listed as 'severe'. You may also describe any unlisted activities that are impacted:

Please provide recommendations for reasonable accommodations that you feel would ensure equal access and/or remove access barriers for the student, and include the rationale for these recommendations.

Other limited activities not listed above: _____

Please add any further information here. If you are documenting a Learning Disability, you may use this space to include achievement test results.

Printed name of certifying professional: _____

Professional Title: _____ License #: _____

Email address: _____ Phone: _____

I certify that student named in this document has given me permission to release all information contained in this form for the purposes of assessment for reasonable accommodations.

Signature: _____ Date: _____