Minnesota State
Community and Technical College

REQUEST FOR DOCUMENTATION

The person named below has requested accommodations and/or disability/related services at Minnesota State Community and Technical College (M State). In order to be eligible to use accommodations, the individual must have a documented disability, as defined by federal law.

Accessibility Resources will use the information you provide to determine whether this person has a disability and is eligible to use accommodations and/or disability-related services while attending M State. In addition, the functional information you provide will assist Accessibility Resources in identifying the appropriate accommodations for this individual.

Student Completes:

Name:_____ Student ID _____Date of Birth:_____

M State home campus (circle one): Detroit Lakes Fergus Falls Moorhead Wadena Online

Medical Professional/Diagnostician Completes:

Diagnosis (i.e. DSM IV or medical): _____

Date of most recent evaluation:_____

Name and title of evaluator_____

List diagnostic protocol used:_____
_____

If the diagnosis is a learning disability, please attach the current psycho-educational evaluation.

Describe the severity of the disability, and the student's functional limitations in an educational setting:

_____
_____
_____
_____

Will the functional limitations described above change over time?_____If yes, please explain:

_____
_____
_____
_____

If appropriate, list the treatments, medications, assistive devices, accommodations or services currently prescribed or in use and describe their impact or expected impact:

_____
_____
_____
_____

Recommendations from professionals who have worked with this person provide valuable information we can use when determining the specific accommodations and/or disability-related services for this individual. Please list any suggestions for accommodations/services you wish to make.

_____
_____
_____
_____

If your suggestions go beyond what can be appropriately provided at MSCTC, we may use your information to suggest referrals to other service providers.
I certify that the information submitted represents this person's **present level of functioning.**

_____
Signature of Professional Date

_____
Print Name and Title

_____
Organization and Address

Please mail, scan and email, or fax the completed form to M State Accessibility Resources. Thank you.

M State Accessibility Resources
1900 28th Avenue South
Moorhead, MN 56560-4899

Fax: 218-299-6869

Email: arteam@minnesota.edu