Documentation Principles & Guidelines:

Documentation Principles

- Student Services uses a combination of information to determine eligibility and reasonable accommodations. Documentation of a specific disability does not translate directly into a specific accommodation or set of accommodations, instead reasonable accommodations are determined on a case-by-case and course-by-course basis.
- Ensuring that accommodations provide effective access requires a deliberative and collaborative process that is responsive to the unique experience of everyone, as advised by the Americans with Disabilities Act, Amendments Act, 2008.
- The rationale for seeking information about a student's condition is to support the higher education professional in establishing disability, understanding how disability may impact a student, and making informed decisions about reasonable accommodations.
- Documentation assists the Student Services staff to:
    - establish a student's eligibility for services
    - understand the impact of a student's condition(s) in an academic environment
    - and determine strategies and reasonable accommodations to facilitate equal access.
- Documentation should be reviewed by examining the functional limitations of the disability on the student and how this supports the need for reasonable accommodations.
- Disability documentation should be treated in a confidential manner and shared only on a need-to-know basis according to both State and Federal laws and regulations.

Documentation Guideline:

A combination of the following forms of documentation will be utilized to support accommodation requests at Southern California University of Health Sciences.

- Student self-report
- Medical and health records
- Psycho-educational/Neuro-psychological reports
- School records (Individualized Education Plans, 504 Plans and Summaries of Performance)
- Observation and interaction

Components of student self-report (information obtained through submitted documentation and during the intake process):

- Description of diagnosed condition(s)
- Description of previous educational experiences
- Description of past use of accommodations or services
- Description of condition's impact related to the academic environment

- Description of current need for reasonable accommodations for individual courses, programs, activities, and facilities.

Components of professionally prepared documentation

Qualified Professional:

- Completed by a qualified professional who is a licensed or otherwise properly credentialed professional (licensed physicians, psychologists, or other qualified professionals),who has appropriate training and experience, and has no close, personal relationship with the student being evaluated.

Clear Diagnostic Statement:

- Documentation must include a clear diagnostic statement identifying the disability and the date of the most current diagnostic evaluation, as well as the date of the original diagnosis, as appropriate.

A Description of Diagnostic Methodology:

- A description of the current diagnostic criteria, evaluation methods, procedures, tests, as well as a clinical narrative interpretation.
- Where appropriate to the nature of the disability (e.g., learning, and cognitive disorders) the report should contain both summary data and specific tests scores.
- Diagnostic methods that are congruent with the disability and current professional practices in the field are expected.
- Methods may include formal instruments, medical examinations, structured interview protocols, performance observations and unstructured interviews. If results from informal or non-standardized methods of evaluation are reported, a clear explanation of their role and significance in the diagnostic process should be included.

Current Functioning and Need for Current Documentation:

- Reflects current functioning: a combination of the results of formal evaluation procedures, clinical narrative, and the individual's self- report is the most comprehensive approach to fully documenting impact of a condition.
- Relatively recent documentation is recommended; common sense and discretion in accepting older documentation of disabilities that are permanent or non-varying are recommended.
- Changes in the functional impact of a condition (e.g., result of growth, development, changes in symptomatology) may warrant more frequent updates in documentation.
- The necessity of recent documentation may depend on the facts and circumstances of the student’s disability and the accommodations requested.

Functional Limitations:

- Documentation should be thorough enough to demonstrate whether and how a major life activity is substantially limited by providing a clear sense of the severity, frequency, and pervasiveness of the disability.

Description of Expected Duration, Progression and Stability of a Condition:

- Documentation must provide information on expected changes or fluctuation of the individual's disability over time if the disability is cyclical or episodic in nature.
- Information should be provided regarding known or suspected environmental triggers that might impact the need for adjusted reasonable accommodations.
- If a condition is unstable, information regarding intervention (including an individual's own strategies); recommended timelines for updates; and potential reevaluations are helpful in determining reasonable accommodations.

Supported Need for Requested Reasonable Accommodations:

- The rationale for seeking information about a student's condition is to support Student Services in establishing disability, understanding how the disability may impact a student, and making informed decisions about reasonable accommodations that facilitate equal access to the institution's courses, programs, facilities, and activities.
- The documentation should include recommendations for reasonable accommodations and services and should be logically related to the student's functional limitations and their specific condition.
- The recommendations by outside agents will be considered and may be adopted when they are congruent with the institution providing equal access to courses, programs, facilities, and services and when they are reasonable in nature. The essential requirements of a program or course are taken into consideration when determining reasonable accommodations.
- Student Services may substitute another reasonable accommodation, if it is as effective and parallel to the one recommended while ensuring that the determination is a deliberative and collaborative process.
- Documentation of a specific disability does not translate directly into a specific accommodation or set of accommodations, instead reasonable accommodations are determined on a case-by-case and course-by-course basis and based upon a deliberative and collaborative process that is responsive to the unique experience of an individual and the unique course and/or program the student is enrolled.
- Student Services has the right to request additional documentation when the need for reasonable accommodations is not supported or deny a requested accommodation when deemed unreasonable.

The following documents will not acceptable:

- Handwritten letters from licensed professionals.
- Handwritten patient records or notes from patient charts.
- Documentation provided by a member of the student's family.
- Diagnoses on prescription pads.
- Self-evaluations.
- Research articles; or
- Original evaluation/diagnostic documents—submit copies of the original documents.
- Documentation stored on electronic devices like CD-Rom or USB or flash drives.
- Pictures of documentation, even if the text is readable.
- Documentation without medical provider signatures

Please contact Student Services for specific documentation guidelines on more comprehensive criteria in the areas of physical, mental, sensory or ADHD.