Texas Christian University

Documentation Guidelines for TCU Students with Disabilities

Physical and Systemic Illness/Injury

Texas Christian University is committed to providing accommodations and services to qualified students with disabilities. In determining reasonable accommodations, the University is guided by the federal definition of “disability” which describes an individual with a disability as someone who has (1) a physical or mental impairment that substantially limits one or more major life activities; (2) a record of such impairment; or (3) is regarded as having such impairment. Any student with a disability may request accommodations from Student Disabilities Services. Examples of physical or systemic illnesses or injuries that may rise to the level of a substantially limiting disability may include, but are not limited to, illnesses such as Diabetes, cancer, lupus, rheumatoid arthritis, Crohn’s disease, Multiple Sclerosis, Muscular Dystrophy, Lyme disease, ulcerative colitis, refractory migraine headaches, loss of a limb or limbs, epilepsy, seizures, tic disorders such as Tourette’s syndrome, postural orthostatic tachycardia syndrome, and paraplegia.

Generally, Student Access and Accommodation does not accommodate minor injuries, transitory illness, and conditions not expected to last six months or more; however, all requests are considered on a case-by-case, individualized basis and such conditions may be reviewed and considered by the Disabilities Services Documentation Review Committee (DSDRC) regarding whether accommodations are appropriate, especially in situations where long-term therapy and follow-up care are required for a protracted period of time.

Documentation Process

In order to establish disability status and eligibility for specific accommodations, academic adjustments, and/or auxiliary aides/services, the Student Access and Accommodation office requires current and comprehensive documentation of the student’s impairment(s). Disability documentation is reviewed by the Disabilities Services Review Committee, and determination of accommodations is made on an individualized, case-by-case basis based on the functional limitations of the disability. It is the student’s responsibility to obtain and provide this information. Approved accommodations are not retroactive; they begin when the student delivers the letter(s) of accommodations to and meets with the instructor(s) to discuss them. Student Access and Accommodation will make the final determination as to whether appropriate and reasonable accommodations are warranted and can be provided to the individual.

Currency of Documentation for Physical and Systemic Illness/Injury

Typically, documentation less than 6 months old is considered current. However, this time frame may vary based on the nature of the disability. Although some medical disorders are chronic or permanent diagnoses, documentation must be provided that addresses the individual’s current level of functioning. For example, some medical disorders are progressive and worsen with time, while others are episodic in nature. Medications and other treatments/therapies may change the impact of the disorder on the individual and may necessitate additional consideration. Accommodations are based on current functional limitations and not on diagnosis alone. Therefore, determination of whether updated documentation will be needed every 6-12 months will be made on a case-by-case basis.
Confidentiality
Student Access and Accommodation is the University agent charged with the responsibility for collecting and maintaining the confidentiality of disability documentation. This information is kept in secure files with limited access within the Student Access and Accommodation office. The expressed written consent of the student will be required prior to releasing medical documentation to a third party.

Guidelines for Disability Documentation
Documentation guidelines for Physical and Systemic Illness/Injury include, but are not limited to, the following:

A qualified professional must conduct the evaluation.
- The student’s disability information should be provided in a typewritten report, signed by the evaluator, and on professional letterhead bearing the name, license number and professional credential(s) of the evaluator. Please attach the professional’s business card.
- It is not appropriate for professionals to evaluate family members, relatives, or business partners.
- Physical disabilities and/or systemic illnesses are considered to be in the medical domain and require the expertise of a licensed physician.
- The diagnosing professional should be a medical specialist such as an endocrinologist, gastroenterologist, immunologist, neurologist, internal medicine specialist, or other medical specialist with 1) comprehensive training and relevant experience and expertise in the area of disability and 2) appropriate licensure/certification in the area for which accommodations are being requested.
- Examples of a qualified professional would be a gastroenterologist for Celiac Disease, an orthopedic specialist for a back injury, a neurologist for Multiple Sclerosis, a rheumatologist for Rheumatoid Arthritis.

A clearly stated diagnosis must be given and the following questions answered:
  a. When was the original diagnosis made?
  b. When did you first treat this student?
  c. How long has the student been under your care as the treating medical specialist?
  d. When was the student’s most recent appointment with you?
  e. Does the student have regularly scheduled appointments with you? How frequently?
  f. When is the next scheduled appointment?
  g. Have you referred the student to another medical specialist for treatment of the disability? For pediatricians, has a referral been made to an adult specialist?

Documentation should reflect current functional limitations.
- Clinicians are encouraged to cite the specific objective measures used to help substantiate the diagnosis.
- Include a description of the symptoms that meet the criteria for diagnosis.
- Include the history of the student’s physical/systemic disorder, including but not limited to date of original diagnosis, date of most recent appointment, and a history of treatment options used.
- Include a statement of the current functional impact of the disorder on learning and other major life activities and the degree to which the disorder impacts the student in the academic and/or residential setting.
- Include relevant information regarding any medications and the degree of impact on functioning in the
academic and/or residential setting.

Documentation necessary to support the diagnosis should be comprehensive.

- Include relevant information regarding current treatment for this condition, and/or any other concurrent conditions, and the degree of impact in the academic and/or residential setting.
- Evidence that alternative etiologies or explanations have been considered in a differential diagnosis and ruled in or out as appropriate. Such alternative explanations may include substance abuse; medication effects; psychiatric, learning, and attention disorders; and motivational factors affecting performance/functioning.
- Accommodations are determined based on the nexus between each requested accommodation and the student’s current functional limitations that are pertinent to the academic setting or the university residential life setting.
- When applicable, medical professionals are encouraged to submit any prior assessments and/or evaluative reports together with the current documentation.
- A Summary of Performance (SOP), Individualized Education Program (IEP) and/or a 504 Plan may or may not be considered fully adequate documentation, but these may be submitted by the student as supporting documentation of the impairment history.
- Prior receipt of accommodations (e.g., in high school) does not guarantee receipt of the same accommodations at TCU. While the law requires that consideration be given to the specific methods requested by a student, it does not imply that a particular accommodation must be granted if it is deemed unreasonable or if other suitable techniques are available.
- Missing disability documentation information may result in a delay in reviewing a student’s request for accommodations.

Please note: Multiple diagnoses may require additional documentation.

When physical disabilities or chronic health/systemic illnesses, injuries, or medical conditions occur in combination with food-related disabilities, ADHD, mental health diagnoses, and sensory, processing, communication or specific learning disabilities, relevant information about these additional diagnoses as they apply to the post-secondary university academic and residential settings should be included. If the additional diagnoses require documentation from another medical, mental health and/or learning specialist, it remains the student’s responsibility to obtain documentation from other specialists to support the need for additional accommodations and services. Current functional limitations should be addressed in relevant documentation. In the case of multiple diagnoses, the student should consult the appropriate documentation guidelines available on the Student Access and Accommodation website: www.tcu.edu/access-accommodation