Idaho State
UNIVERSITY

Disability Services
Rendezvous Building, Room 125
921 S. 8th Avenue, Pocatello, ID 83209-8121

Documentation of Hearing Loss

Student Name:_____ DOB:____/____/_____ has requested disability-related accommodations from the Disability Services office at Idaho State University (ISU) in regards to a hearing impairment. The Americans with Disabilities Amendment Act and Section 504 of the Rehabilitation Act of 1973 protect individuals with disabilities from discrimination and entitles these individuals to reasonable accommodations. In order to establish eligibility, documentation must indicate a disability that substantially limits one or more major life activities. A diagnosis alone will not qualify an individual for accommodations. The documentation must also support the request for accommodations.

A current (within one year) audiogram and audiological report is required to document hearing loss, along with this form. The completed form and documentation may be faxed to (208) 282-4617 or it may be mailed to the address at the top of this page. ISU Disability Services welcomes any additional documentation you would like to include.

TO BE COMPLETED BY YOUR AUDIOLOGIST

1. **Contact with Student**
   a. Date of initial contact with student: _____
   b. Date of last contact with student: _____
   c. Frequency of appointments with student (e.g., once a week, once a month)_____

2. **Diagnosis**
   a. Date of Diagnosis: _____
   b. DSM-V or ICD Diagnosis: _____
   c. Does this disorder substantially limit the student? □ Yes □ No
      i. If yes, please describe: _____
      _____
      _____
      _____

3. **Clinical Description of Diagnosis:** *Please check all relevant symptoms and add additional symptoms not listed here in the space provided below.*

Reliability of Test Findings:

□ Poor □ Fair □ Good □ Excellent

Please explain the reliability of responses or inconsistencies:

_____
_____
_____

Severity:

□ Mild □ Moderate □ Severe □ Profound

Please explain the severity of the condition below:

_____
_____
_____

Duration:

□ Chronic □ Episodic □ Short-term

Please explain the duration of the condition below:

_____
_____
_____

Prognosis:

□ Stable □ Fluctuating □ Declining

If the condition is expected to decline, please describe the expected progression of the hearing loss.

_____
_____
_____

4. Treatments, medications, assistive devices/services currently prescribed or in use:

_____
_____
_____

5. Functional Limitations: *Is there clear evidence that the student's symptoms associated with the hearing loss are interfering with or reducing the quality of at least one of the following?*

Academic Functioning	
Social Functioning	
Work Functioning	
Language Functioning	

6. **Recommended accommodations to facilitate effective communication in the following settings:** *Please provide recommended reasonable accommodations and indicate the reason these accommodations are warranted.*

   a. Face-to- face meetings (e.g., counseling, appointments, meetings with the professor)

   _____

   _____

   b. One-on-one conversations/sessions:

   _____

   _____

   c. Small group conversations:

   _____

   _____

   d. Large group conversations:

   _____

   _____

   e. Large auditorium-style classroom with 50+ students:

   _____

   _____

   f. Small classroom with <50 students:

   _____

   _____

   g. Movies and other audio media:

   _____

   _____

Certifying Professional

Name (*print*): _____ Date: ____/____/_____
Profession:_____License Number:_____
Office Address:_____
Phone:_____ Fax:_____ Email Address:_____

Certifyng Professional Signature:_____

Note: Please attach recent Audiology, ENT, Speech Language Pathology, or other pertinent medical documentation. Current (within 1 year) audiogram and report are required.