Rochester Institute of Technology
Disability Documentation Guidelines

Under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and assured services. In order to establish that an individual is covered under the ADA, the documentation must indicate that a disability currently exists and it substantially limits some major life activity, including learning.

Listed below is information regarding documentation submitted to RIT, which is based on suggested practices from AHEAD (Association on Higher Education and Disability).

In most cases an IEP, 504 Plan or brief note from a physician does not contain the information outlined in the points below, so is not sufficient as documentation. Documentation must be from a treating professional who is not employed by RIT or NTID.

All disability information you provide to the RIT Disability Services Office will be kept confidential and used and disclosed to others only on a need-to-know basis to permit faculty or staff member(s) to complete or manage your request, with others at your request, or as otherwise required under applicable law. For additional information on how your information may be used, please review RIT’s Privacy Statement posted at www.rit.edu/privacystatement.html.

- **The credentials of the evaluator(s)**
  Submitted documentation should be produced by a licensed or otherwise properly credentialed professional who has undergone appropriate and comprehensive training, has relevant experience, and has no personal relationship with the individual being evaluated.

- **A diagnostic statement identifying the disability**
  Submitted documentation should include a clear diagnostic statement that describes how the condition was diagnosed, provides information on the functional impact, and details the typical progression or prognosis of the condition. Use of diagnostic codes from the Diagnostic Statistical Manual of the American Psychiatric Association (DSM) is helpful in providing this information; a full clinical description conveying the necessary information is also acceptable.

- **A description of the diagnostic methodology used**
  Submitted documentation should include a description of the diagnostic criteria, evaluation methods, procedures, tests and dates of administration, as well as a clinical narrative, observation, and specific results. Where appropriate to the nature of the disability, having both summary data and specific test scores (with the norming population identified) within the report is recommended.

Diagnostic methods that are congruent with the particular disability and current professional practices in the field are recommended. Methods may include formal instruments, medical examinations, structured interview protocols, performance observations and unstructured interviews. If results from informal, non-standardized or less common methods of evaluation are reported, an explanation of their role and significance in the diagnostic process will strengthen their value in providing useful information.
- **A description of the current functional limitations**
  Submitted documentation should include information on how the disabling condition(s) currently impacts the individual. 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. The 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 condition(s).

  Relatively recent documentation, dated within 1-5 years of the request, is acceptable in most circumstances. Older documentation of physical conditions that are permanent or non-varying is acceptable. Please contact the Disability Services Office if more information is required.

- **A description of the expected progression or stability of the disability**
  It is helpful when documentation provides information on expected changes in the functional impact of the disability over time and context. Information on the cyclical or episodic nature of the disability and known or suspected environmental triggers to episodes provides opportunities to anticipate and plan for varying functional impacts. If the condition is not stable, information on interventions (including the individual’s own strategies) for exacerbations and recommended timelines for re-evaluation are most helpful.

- **A description of current and past adjustments, services and/or medications**
  A description of both current and past medications, auxiliary aids, assistive devices, support services, and adjustments, including their effectiveness in ameliorating functional impacts of the disability, is very helpful. A discussion of any significant side effects from current medications or services that may impact physical, perceptual, behavioral or cognitive performance is helpful. Please note that RIT has no obligation to provide adjustments previously provided by outside entities.

- **Recommendations for adjustments, adaptive devices, assistive services, compensatory strategies, and/or collateral support services**
  Recommendations from professionals with a history of working with the individual may provide information useful in the planning process. Please note that RIT has no obligation to provide or adopt recommendations made by outside entities.

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