To ensure the provision of reasonable and appropriate services for students with physical or sensory disabilities, the Office of Disability Services requires students to provide current and comprehensive documentation of their disability and its impact on their education. Please complete and return this form to our office. We thank you in advance for your assistance.

Student’s name: ______________________________________________________________

1. Name/Type of Disability (diagnosis):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Date of initial Diagnosis: _____________________________

3. Please describe testing procedures, methods and/or instruments used to determine diagnosis for the above mentioned disability, illness or chronic medical condition (Please include any specific results of such tests and attach results):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Describe any treatment plan(s), including a description of student’s responsibility:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Indicate which major life activity(ies) is/are substantially limited by this disability/chronic health condition (circle all that apply): caring for oneself, performing manual tasks, seeing, hearing, speaking, breathing, learning, working, other: __________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
6. Describe any additional functional limitations imposed by the disability/chronic health condition, particularly in an academic setting (e.g. writing, taking notes, carrying heavy awkward items distances over 200 feet, using stairs, walking distances in inclement weather, etc.).

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

7. Any suggested accommodations:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

8. Summary and recommendations based on the above diagnosis:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Signature: ____________________________ Date: _________________

Print Name and Title: _____________________________________________

Area of Specialty: _______________________________________________

State License: ___________________________ License Number: __________

Address: _______________________________________________________

Phone: ___________________________ Fax: _________________________