

STUDENT ACCESSIBILITY SERVICES
STANDARD DOCUMENTATION FORM



FIRST NAME: _____ **LAST NAME:** _____

DOB: _____ **P#:** _____

Diagnosis/Diagnoses: _____

Are you currently providing treatment for these diagnosis/diagnoses? Yes No

Specifically describe how the condition contributes to functional limitations in an academic setting for this person and to what degree the person is limited. _____

What test(s), if any, were done to determine diagnosis and/or limitations? _____

If this person is taking any prescribed medications, please describe any functional impairment these medications may likely cause. _____

What reasonable academic accommodations would you support on behalf of this person?

Signed: _____ **Date:** _____

NAME AND TITLE OF QUALIFIED PROFESSIONAL

License #: _____ State: _____

Name: _____ Title: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Please email completed form to banks.a@ptc.edu or fax to (864) 941-8378.

Evaluation report and/or documentation forms themselves do not automatically qualify student(s) for reasonable accommodations.