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. ____
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____

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. ____
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____

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) 941-8768**.

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