

**DISABILITY 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 [dailey.b@ptc.edu](mailto:dailey.b@ptc.edu) or fax to (864) 941-8768.

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