CHARLESTON SOUTHERN UNIVERSITY

Documentation of Disability

To be completed by the diagnosing professional, who should not be a relative of the student

PLEASE PRINT

Student's Name: _____Date of Birth: _____

Diagnosis: _____ Date of Diagnosis: _____

Date of Initial Contact with Student: _____Date of last visit: _____

Is the condition:

☐ Physical Disability ☐ Psychological Disability ☐ Neurological Disability

☐ Permanent ☐ Temporary

If temporary, what is the anticipated length of disability? _____

Briefly describe (print) the student's medical condition(s) and physical limitation(s).

Diagnostic criteria/test used:

Treatments/medications/devices or resources currently prescribed (name of medication and dosage):

Expected duration, stability, or progression of the condition:

Is the student functionally impaired by one or more of the above listed conditions? _____Yes _____No

If yes, specifically describe how the condition contributes to functional impairments or limitations in an educational setting and to what degree.

Has the student experienced periods of time during which the functional impairment(s) remit?

_____Yes _____No

If yes, how long are these periods on average? _____

How likely is the student to be functionally impaired:

30 days from now:_____

90 days from now: _____

6 months from now: _____

Permanently: _____ If permanent, please explain.

_____ _____

Signature of Health Professional Date

_____ _____

Credentials/ License # of Professional Phone Number and/or Email