

**Arkansas State University  
Access & Accommodation Services  
Phone 870-972-3964/Fax 870-972-3351**

**PROFESSIONAL DOCUMENTATION OF DISABILITY**

**\*\*\*This form is confidential and is to be completed by a physician or licensed professional. The purpose of this form is to assist A-State A&AS Services in providing accommodations to support the student in his/her academic career.**

Please include with this form a copy of your evaluation report concerning this student.

Yes  No

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

Student Address: \_\_\_\_\_

Diagnosis and Description of the Disabling Condition: \_\_\_\_\_

\_\_\_\_\_

What is the date of initial diagnosis? \_\_\_\_\_

What is the date of the last diagnosis? \_\_\_\_\_

Please list specific recommendations: \_\_\_\_\_

\_\_\_\_\_

Current functional limitations that may inhibit this student in the educational environment:

\_\_\_\_\_

\_\_\_\_\_

Do you consider the individual's illness/disorder to be a disability? Yes  No

Do you consider this disability to be permanent? Yes  No

*Print* name and title of examining physician or professional: \_\_\_\_\_

Address and phone number of examining physician or professional: \_\_\_\_\_

\_\_\_\_\_

Signature of Examining Physician or Professional

Date Signed

**\*\*\*Note: Signature must be the signature of physician or professional.**