Dear Health Care Provider,

Academic Resources of Dalton State College coordinates services for students with disabilities as mandated by federal law. To receive services, students voluntarily register with the Disability Support Services office. In order for a student to be considered for eligibility, the disability must result in substantial limitations to one or more major life activities. It is the student’s responsibility to provide detailed documentation.

We request that you please help this student by furnishing as much of the following information as you may have available and as quickly as possible. Only documentation signed by a professional licensed to diagnose the particular disability can be accepted.

Thank you for helping us to enhance this student’s opportunity for academic success. Please do not hesitate to contact me at 706/272-2524 or at aroberson@daltonstate.edu if you need additional information or have questions. Please feel free to fax this form to me at 706/272-2570.

Sincerely,

Andrea Roberson

Andrea Roberson, M.P.A.
Coordinator, Disability Support Services
Dalton State College

Please complete this form legibly and thoroughly.

PATIENT/STUDENT NAME: __________________________________________

1. What is the student’s diagnosis, including diagnostic codes for each?
   _________________________________________________________________
   _________________________________________________________________
2. What are the functional impairments and/or limitations as a result of the disability?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

3. What is the level of impairment? _____Mild _____ Moderate _____ Severe

Please elaborate on the level of impairment:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

4. What is the expected duration? _____ Chronic _____ Episodic _____ Short-term

Please elaborate on the expected duration:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

5. Please indicate how the impairments/limitations may affect or interfere with academic performance or housing placement:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

6. List the student’s current medication(s) and adverse side effects (if applicable for the above-mentioned disorder).

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________
7. State specific recommendations regarding academic adjustments, housing considerations, and/or other services that are warranted or suggested based upon the student’s functional limitations.

8. Additional Comments:

Date: ________________

Signature of Provider: ________________________________

Name/Title: ________________________________

Address: ________________________________________________

Phone: ________________________________

Fax: ________________________________