DOCUMENTATION FOR ACCOMMODATIONS REQUEST

A student, or prospective student, is seeking on-campus accommodations for a reported disability. Documentation of disabilities is required from a qualified professional.

Client/Patient ____________________________________________ Last _______ First _______ MI _______

Date of Birth ____________________________ SS# ____________________________

Diagnosis/Diagnoses ____________________________________________

Are you currently providing treatment for this person?  □ Yes □ No

Do(es) the condition(s) listed above have a substantial limitation on a major life activity for this person?  □ Yes □ No

Which of these major life activities is limited?

☐ Walking  ☐ Seeing  ☐ Hearing  ☐ Breathing  ☐ Doing manual tasks
☐ Self-care  ☐ Learning  ☐ Social interaction  ☐ Thinking  ☐ Concentrating
☐ Reading  ☐ Writing  ☐ Speaking  ☐ Calculating  ☐ Working
☐ Other ____________________________________________

Specifically describe how the disorder contributes to functional limitations in a higher educational setting for this person, and to what degree.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What tests, if any, were done to determine diagnosis and/or limitations?

________________________________________________________________________

________________________________________________________________________

If disabled, is this disability considered  □ Permanent  □ Temporary
If this person is taking any prescribed medications, please describe any functional impairment these medications may likely cause.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What reasonable academic accommodations would you recommend in this case?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signed ___________________________ ___________________________
(Name and Title of Medical/Clinical Professional) (Date)

License # ___________________________ State ___________________________
(Please print or type.)

Name ___________________________ Title ___________________________
Address ___________________________ Phone ___________________________
________________________________________________________________________
Fax ___________________________

Evaluation reports and/or documentation forms themselves do not automatically qualify a student for services from Trident Technical College, or for reasonable accommodations. The Services for Students with Disabilities office will make final decisions regarding accommodations and any other services they or Trident Technical College may provide.

Please return this form (both sides) by mail, fax or in person to:

________________________________________________________
(Counselor's Name)

Trident Technical College
Services for Students with Disabilities
PO Box 118067, CD-M
Charleston, South Carolina 29423-8067
Phone: 843.574.6131 | Fax: 843.574.6812 | TDD: 843.574.6351