DISABILITY SUPPORT SERVICES
HEALTH CARE PROFESSIONAL FORM

ARKANSAS STATE UNIVERSITY
THREE RIVERS

Student Information:

Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **(Home)** _____ **(Cell)**

Instructions: This form must be completed by a HEALTH CARE PROFESSIONAL.

The above-named student is requesting accommodations at Arkansas State University Three Rivers. In order to respond to the student's request, we require that you complete the information below. Please complete this information, and attach additional pages as necessary.

Please note that this form must be completed PRIOR TO RECEIPT of accommodations.

Professional's Contact Information (Please Print):

Physician's Stamp:

Name: _____ **Address:** _____

Phone: _____ **City:** _____

Fax: _____ **State:** _____ **Zip:** _____

License #: _____ **Disability Type: (Circle):** Physical Neurological ADHD Psychological

Print Clearly (if more space is needed, please use office letterhead)

What is the student's relevant diagnosis/impairment? How long has this student had this diagnosis?

_____

_____

Is the impairment expected to last six months or longer? _____ Yes _____No

Describe the present symptoms, their frequency and severity, and how the disability interferes with one or more major life activities:

_____

_____

_____

What treatment and/or medication(s) is the student undergoing? Please list medications and dosages.

_____

_____

_____

Do you expect these symptoms to continue for the foreseeable future? _____ Yes _____ No
If no, when you do expect the symptoms to abate? _____

How will the student be able to manage these symptoms in other campus environments (e.g. classrooms, library, etc.)?

_____

_____

For episodic conditions, how frequent are the episodes, and what is their duration and severity?

_____

_____

_____

What accommodations are reasonable and appropriate (i.e. to maintain general wellness) for the student?

_____

_____

_____

Are there other effective means that would have similar benefits as the requested accommodation?

_____

_____

Is the impact of the condition life-threatening if the request is not met? _____ Yes _____ No

_____ I have attached the documentation with the results of evaluations which led to this diagnosis.

Professional's Signature: _____ Date: _____

Print Name: _____

Please return the completed form to:

Disability Services Office
Arkansas State University Three Rivers
One College Circle
Malvern, AR 72104

Phone: 501.332.0215 | **Fax:** 501.337.9382 | **E-mail: vsmith**@asutr.edu

Students: You must set up an appointment to discuss Disability Services at Arkansas State University Three Rivers. This appointment will last approximately one hour. Appointments can be made with Mrs. Vergina Smith-Joachim.