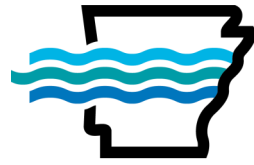


**DISABILITY SUPPORT SERVICES
HEALTH CARE PROFESSIONAL FORM**



**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):

Name: _____ Address: _____
Phone: _____ City: _____
Fax: _____ State: _____ Zip: _____
License #: _____ Disability Type: (Circle):

PHYSICIAN'S STAMP:

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

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.