

## Documentation for Communication Disorders

The Office of Student Well-Being and Support (OWBS) provides support services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Student Disability Services will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in OWBS. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

Please complete this form, fill out the Healthcare Provider Information section on the last page, sign it, then return it to the student, who will give it to OWBS at the College of Coastal Georgia.

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Print Name

\_\_\_\_\_

Student ID#

**Primary Diagnosis:** \_\_\_\_\_

Date of onset: \_\_\_\_\_

**Secondary Diagnosis (if any):** \_\_\_\_\_

Date of onset: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Describe the functional/physical limitations that affect this student's ability to conduct major life activities.

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Describe current functional limitations, which affect this student in the academic setting, and suggestions for accommodations (i.e., frequent breaks, extra time on tests).

**Limitations**

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**Recommendations**

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Describe the history of the communication disorder from early childhood or from the initial onset.

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Summarize present symptoms for the communication disorder.

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List treatments, medications, accommodations/auxiliary aids, services currently prescribed or in use.

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**Healthcare Provider Information (In the space provided, please attach a business card.)**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Please print)*

\*\*Provider name: \_\_\_\_\_ Title: \_\_\_\_\_ License #: \_\_\_\_\_

Attach Business Card Here