Phone (843) 863-7159 • Strom Thurmond Building, Student Success Center • Fax (843) 863-8030 • awatson@csuniv.edu

Documentation for a PSYCHOLOGICAL Disability

To be completed by the diagnosing professional, who should not be a relative of the student
PLEASE PRINT

Student's Name: _____ Date of Birth: _____

Diagnosis: _____ Date of Diagnosis: _____

Date of Initial Contact with Student: _____ Date of last visit: _____

Is the condition: _____Permanent? _____Temporary?

If temporary, what is the anticipated length of disability? _____

Briefly describe (print) the student's medical condition and physical limitations.

Diagnostic criteria/test used:

Treatments/medications/devices or resources currently prescribed (name of medication and dosage):

Expected duration, stability, or progression of the condition:

Is the student functionally impaired by one or more of the above listed conditions? _____Yes _____No

If yes, specifically describe how the condition contributes to functional impairments or limitations in an educational setting and to what degree.

Has the student experienced periods of time during which the functional impairment(s) completely (or nearly completely) remit? _____Yes _____No. *If yes*, how long are these periods on average?

How likely is the student to be functionally impaired to the same or greater degree 30 days from now:_____ 90 days from now: _____
6 months from now: _____ Permanently: _____

If permanent, please explain.

_____ _____
Signature of Health Professional Date

_____
Credential License # of Health Professional

Name and address of Health Professional (please print)

Phone:

Fax:

Please Return to:

Office of Disability Services/Strom Thurmond Building
Charleston Southern University
9200 University Boulevard
Charleston, SC 29423
Phone: 843.863.7159
Fax: 843.863.8030