



NORTH CAROLINA AGRICULTURAL AND TECHNICAL STATE UNIVERSITY

Accessibility Resources

Student First and Last Name: _____

IMPORTANT: The Americans with Disabilities Amendment Act defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Thorough completion of this form is necessary for the Office of Accessibility Resources to determine eligibility for accommodations. Insufficient information may result in ineligibility. Complete one documentation form for each diagnosis or condition. **Please note the following information:**

- ❖ This is not a mandatory form, but may be used by treating providers as a means of furnishing OARS with information and documentation to support the student's accommodations request(s).
- ❖ Documentation must reflect that the condition substantially limits a major life activity or major bodily function. OARS utilizes flexibility and discretion in determining how recent documentation must be. Changing conditions and/or changes in how a condition impacts the individual may warrant more frequent updates.
- ❖ Recommendations are welcomed and considered, however OARS makes the ultimate determination on eligibility and reasonable academic adjustments necessary to provide equal access for participation in academic courses, programs and activities.

TO BE COMPLETED BY DIAGNOSTICIAN OR TREATING PROFESSIONAL

Date of Birth: _____ Date of Diagnoses: _____

Specific Diagnoses: _____

Date of most recent office visit: _____ Does this disorder substantially limit the student? YES NO

Attach any supporting documentation: e.g., psycho-educational evaluations for learning disabilities, audiology reports, vision reports, etc. **supporting documentation attached**

If uncertain, please refer to the documentation guidelines

Current Impact and Functional Limitations:

Describe the student's level of functioning and limitations that could impact the student on a college campus and in an academic setting: _____

_____.

Medication:

Treatments, medications, assistive technology devices/services currently prescribed or in use: _____
_____.

How will medication adversely impact this student? *(Please provide a clear rationale based on the level of impairment)* _____

_____.

Expected duration of the impact of the disability:

- Temporary-Anticipated recovery date: _____ Permanent
 Chronic
 Episodic/Recurring

Expected progression or stability of the impact of the disability: _____

_____.

Recommended Accommodations:

Recommendations should be directly linked to the impact or functional limitations associated with the disability, and include a clear rationale based on level of impairment.

Qualifications of Clinician/Provider:

Name of Diagnostician/Professional: _____

Signature: _____ Date: _____

License #: _____

Organization: _____ Phone #: _____

Please submit the accompanying report to:

Accessibility Resources
1601 East Market Street
Murphy Hall, Ste. 01-Lower Level
Greensboro, NC 27411
Main Number: 336-334-7765 Fax: 336-334-7333
Email: oars@ncat.edu