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THE WOMEN'S COLLEGE

SECTION I: STUDENT REQUEST

Student Name: _____ Birthdate: _____

I am requesting additional educational support services through Accommodations and Academic Resources Services (AARS) at Scripps College which requires current and comprehensive documentation of my disability and functional limitations.

Please respond to the following questions as soon as possible and return to AARS by email or fax.
Email: aasrs@scrippscollege.edu Fax: 909-607-7081

I authorize Accommodations and Academic Resources Services at Scripps College to contact my provider if clarification is needed.

Student Signature: _____ Date: _____ SID #: _____

SECTION II: DISABILITY VERIFICATION

Please provide the following information regarding the student above to help us determine reasonable educational and physical accommodations:

1. Diagnosis: _____

DSM V Code: _____ Severity: Moderate Severe Remission

2. How does this condition substantially limit major life activities, please provide examples:

3. List other functional limitations/information helpful in determining accommodations in an educational setting:

4. Is this student taking any medications? Yes No
If so, how does taking this medication as directed currently impact the student?

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SECTION III: CLINICAL RELATIONSHIP

1. What is the initial date of diagnosis(es)? _____

2. Is the individual currently under your care for this diagnosis(es)? Yes No

3. We look for reliable evidence of an established client-provider relationship. Please list the date you and the individual established a client-provider relationship, as well as any dates you treated the individual in the last six months to 1 year.

SECTION IV: LICENSING INFORMATION

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

Name of Physician or Certified/Licensed Professional: _____

Title/Specialty: _____ License or Certification #: _____

Address: _____ City: _____ State:_____

Zip Code: _____ Phone Number: _____

By signing below, I certify that I conducted or formally supervised the diagnostic assessment of the individual named above or have reviewed and concur with the diagnosis provided by the assessing clinician. I affirm that the information contained in this documentation is accurate to the best of my knowledge and that I am not related to this student.

Signature of Physician or Certified/Licensed Professional:

_____ _____