

8. Indicate accommodations you recommend to support this student in an academic setting:

(Functional Limitation) (Reasonable Accommodation)

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9. List current medication, dosage and frequency:

10. Identify how the medication might adversely impact the student in an academic setting:

11. Secondary Diagnosis: _____

Date of Diagnosis: _____

12. Please provide any additional information that would be helpful in providing support to the student: _____

DOCUMENTATION COMPLETED BY ANYONE OTHER THAN THE TREATING PROFESSIONAL WILL NOT BE ACCEPTED

13. Printed Name and Credentials of Treating Professional: _____

Area of Specialty: _____

Address: _____

Phone: _____ FAX: _____

Signature: _____ Date: _____

RETURN THIS FORM WITH ANY ACCOMPANYING DOCUMENTATION TO:

Office of Disability Services

University of North Carolina at Charlotte

9201 University City Boulevard, Fretwell 230 Charlotte, NC 28223-0001

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