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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?
, 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

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

Promoting Academic Excellence in a Christian Environment

