Disability Services Office, SC229 | 2740 West Mason St, Green Bay, WI 54303 | 920-498-6904 | Fax: 920-491-3792
disability.services@nwtc.edu

# DISABILITY DOCUMENTATION FORM

**To be completed by a qualified medical doctor, psychiatrist, psychologist, counselor, or social worker**
**Please type or print neatly and use a separate paper if needed**

**Student Name: _____ D.O.B: _____**

1. **What is the diagnosis? _____**
2. **Level of severity: Mild _____ Moderate _____ Severe _____**
3. **When was the diagnosis made? _____**
4. **When was your last contact with the above-named student? _____**
5. **Is the condition: Temporary_____ Permanent _____**
6. **Please provide an explanation of the disability, medical condition, or symptoms:**

   _____

   _____
7. **If a treatment plan exists, what is the plan in brief? _____**

   _____

   _____
8. **Provide a description of the student's functional limitations as a result of this condition, and how they might impact on this student's academic activities (such as reading, writing, note-taking, concentration, studying, interactions with others… instructors and students, etc.)**

   _____

   _____

   _____

   _____

**Professional's Signature: _____ License #: _____**

**Print or type name and title: _____**

_____

**Address: _____**

**Phone: _____ Date: _____**