Documentation for Learning Disabilities

Kennesaw State University's Student Disability Services provides academic services and accommodations students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Disability Services will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in Disability Services. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other informatio you think would be relevant to the student's academic adjustment.

Please complete this form, fill out the Healthcare Provider Information section on the last page, sign it, then return it to the student, who will give it to the Disability Services Provider at Kennesaw State University.

Date R I % L U W K Print Name Student ID#

Primary Diagnosis: De

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scribe current functional limitations, which affect this student in the academic setting, and suggestions for accommodations (i.e., frequent breaks, extra time on tests).

Limitations	Recommendations


KENNESAW STATE
UNIVERSITY
DIVISION OF STUDENT AFFAIRS

Describe objective evidence that symptoms are associated with significant functional impairment in the academic setting in one or more of the following areas: reading, mathematics, or written language.

Explain the academic and cognitive/linguistic limitation(s) have been identified and ruled out (e.g. low cognitive ability, other mental or neurological disorders, lack of adequate education, visual or auditory dysfunction, emotional factors such as anxiety or depression, cultural/language differences, poor motivation, symptom exaggeration).

Healthcare Provider Information (In the space provided, please attach a business card.)

Provider Signature:_____ Date:_____

(Please print)

**Provider name: Title: License #: