SIMMONS COLLEGE

DISABILITY SERVICES
ACADEMIC SUPPORT CENTER, SUITE P304
300 The Fenway • Boston, Massachusetts 02115.5898
phone: 617.521.2473 fax: 617.521.3079

Student Name: ___________________________________
Social Security Number: ___________________________
Simmons ID Number: _____________________________

Simmons College requires the submission of documentation for students with physical disabilities and/or systemic illnesses who request accommodations through the College. Students must submit a current diagnosis (within the last three years) by a licensed health professional (physician, psychiatrist, neurologist or other medical specialist). The age of acceptable documentation is dependent upon the disabling condition, the current status of the student and the student's specific request for accommodations. Disabilities that are sporadic or degenerative may require more frequent evaluations. Please have your health professional complete the following information:

(Add attachments as necessary)

■ Section One – Diagnosis Information

PRIMARY DIAGNOSIS: ____

DATE OF ESTABLISHMENT: ______________________ **DATE OF LAST EVALUATION:** ______________________

DESCRIBE STUDENT'S PHYSICAL HEALTH CONDITION: ______________________________________

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■ Section Two – Evaluation Procedures

LIST WHAT ASSESSMENT PROCEDURES AND/OR EVALUATION INSTRUMENTS WERE USED TO MAKE THE DIAGNOSIS (PROVIDE RESULTS):

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PROCEDURE/ INSTRUMENT RESULTS DATE

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PROCEDURE/ INSTRUMENT RESULTS DATE

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PROCEDURE/ INSTRUMENT RESULTS DATE

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PROCEDURE/ INSTRUMENT RESULTS DATE

DESCRIBE STUDENT'S PRESENT SYMPTOMS THAT MEET THE CRITERIA FOR THE DIAGNOSIS: ______________________________

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■ Section Three – Impact of Diagnosis and Recommendations

DESCRIBE LIMITATIONS ON LEARNING OR OTHER MAJOR LIFE ACTIVITY AND THE DEGREE TO WHICH IT IMPACTS THE INDIVIDUAL IN THE LEARNING CONTEXT: ________________

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WHAT IMPACT DOES THE INDIVIDUAL'S PSYHICAL HEALTH (STATIC OR CHANGING) HAVE UPON THE DEMANDS OF THE ACADEMIC PROGRAM? ________________________________

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WILL MEDICATION IMPACT THE STUDENT'S ABILITY TO MEET THE DEMANDS OF THE POST-SECONDARY ENVIRONMENT? ________________ **IF YES, DESCRIBE:** ___________________
YES / NO

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PLEASE PROVIDE A STATEMENT REGARDING THE USE OF PHYSICAL THERAPY OR OTHER TREATMENTS (IF APPROPRIATE): ____

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PLEASE PROVIDE A LIST OF APPROPRIATE ACCOMMODATIONS RECOMMENDED AND HOW THEY WILL ADDRESS THE STUDENT'S SPECIFIC NEEDS: ______________________________

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OTHER COMMENTS: ____

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EVALUATOR: ____
NAME TITLE LICENSE NUMBER

ADDRESS: ____
STREET NAME AND NUMBER SUITE

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CITY STATE ZIP PHONE NUMBER

____
SIGNATURE DATE