



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 who have experienced head/traumatic brain injuries who request accommodations through the College. Students must submit a current diagnosis (within the last three years) by a licensed health professional (physician, psychologist, 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. 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 PRECIPITATING EVENT(S) WHICH RESULTED IN THE INJURY: _____

■ Section Two – Evaluation Procedures

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

PROCEDURE/ INSTRUMENT	STANDARDIZED SCORE	PERCENTILE SCORE	DATE
PROCEDURE/ INSTRUMENT	STANDARDIZED SCORE	PERCENTILE SCORE	DATE
PROCEDURE/ INSTRUMENT	STANDARDIZED SCORE	PERCENTILE SCORE	DATE
PROCEDURE/ INSTRUMENT	STANDARDIZED SCORE	PERCENTILE SCORE	DATE

DESCRIBE STUDENT’S RESIDUAL SYMPTOMS THAT MEET THE CRITERIA FOR THE DIAGNOSIS: _____

■ 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: _____

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

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

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

OTHER COMMENTS: _____

EVALUATOR: _____
NAME TITLE LICENSE NUMBER

ADDRESS: _____
STREET NAME AND NUMBER SUITE

CITY STATE ZIP PHONE NUMBER

SIGNATURE DATE