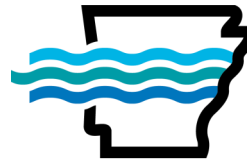


**DISABILITY SUPPORT SERVICES  
HEALTH CARE PROFESSIONAL FORM  
TRIO STUDENTS**



**ARKANSAS STATE  
UNIVERSITY  
THREE RIVERS**

**STUDENT INFORMATION:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell)

**INSTRUCTIONS: THIS FORM MUST BE COMPLETED BY A HEALTH CARE PROFESSIONAL.**

*The above-named student is requesting accommodations at Arkansas State University Three Rivers. In order to respond to the student's request, we require that you complete the information below. Please complete this information, and attach additional pages as necessary.*

**PLEASE NOTE THAT THIS FORM MUST BE COMPLETED PRIOR TO RECEIPT OF ACCOMMODATIONS.**

**PROFESSIONAL'S CONTACT INFORMATION (PLEASE PRINT):**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ City: \_\_\_\_\_  
Fax: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
License #: \_\_\_\_\_ Disability Type: (Circle):

**PHYSICIAN'S STAMP:**

PHYSICAL      NEUROLOGICAL  
ADHD          PSYCHOLOGICAL

**PRINT CLEARLY (IF MORE SPACE IS NEEDED, PLEASE USE OFFICE LETTERHEAD)**

What is the student's relevant diagnosis/impairment? How long has this student had this diagnosis?

Is the impairment expected to last six months or longer? \_\_\_\_\_ Yes      \_\_\_\_\_ No

Describe the present symptoms, their frequency and severity, and how the disability interferes with one or more major life activities:

What treatment and/or medication(s) is the student undergoing? Please list medications and dosages.

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Do you expect these symptoms to continue for the foreseeable future? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, when you do expect the symptoms to abate? \_\_\_\_\_

How will the student be able to manage these symptoms in other campus environments (e.g. classrooms, library, etc.)? \_\_\_\_\_

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For episodic conditions, how frequent are the episodes, and what is their duration and severity?

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What accommodations are reasonable and appropriate (i.e. to maintain general wellness) for the student?

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Are there other effective means that would have similar benefits as the requested accommodation?

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Is the impact of the condition life-threatening if the request is not met? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_ I have attached the documentation with the results of evaluations which led to this diagnosis.

Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Please return the completed form to:

**Disability Services Office**

Arkansas State University Three Rivers

One College Circle

Malvern, AR 72104

501.332.0213 | rwright@asutr.edu

Students: You must set up an appointment to discuss Disability Services at Arkansas State University Three Rivers. This appointment will last approximately one hour. Appointments can be made with Richard Wright.