CONVERSE

Disability Services
Division of Student Development & Success
580 East Main Street
Spartanburg, SC 29302-0006
Fax (864) 577 -2052
Phone (864) 596.-9027

For more information contact:

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Physical/Motor Disability

Student's Name:____

To be completed by a Qualified Licensed Provider:

Converse College provides testing and classroom accommodations for students with a verified and substantially limiting disability. A student's documentation must demonstrate the existence of a condition covered by the Americans with Disabilities Act (ADA: 1990). **The ADA defines a disability as a physical or mental impairment that substantially limited one or more major life activities.** Documentation of such impairment must be derived from a licensed provider who is not a relative of the student. Specific information regarding the condition as well as its impact on learning must be provided. If the student requires disability accommodations those conditions must be addressed with the documentation that meets Converse's requirement s for those impairments. Please contact our office at (864) 596-9027 for more information.

Please attach a separate sheet of paper or include a separate report if the space provided is not sufficient.

1. What is the student's diagnosis?____
____

    a. State the current symptoms:____
    ____
    ____

    b. How is the disability substantially limiting?___________________________________
    ____
    ____

    c. State the frequency of your appointments with this student and the date of your last contact with the student? ____

2. Are there any significant impairments that have resulted from this physical condition? If so, what are they and how are they substantially limiting? ______________________________
____
____

Student's Name: ____

3. If applicable, list and describe the measures/ instruments used to determine the level of impairment. **Please attach the diagnostic report evaluating the patient's condition including all symptoms and laboratory findings.**

4. List the student's current medication(s) and adverse side effects, if applicable.

____
____
____

   a. Are there any significant limitations to the student's functioning directly related to the prescribed medication? Yes __________ No_________ NA___________
   b. If yes, please describe. ____
   ____

5. Please specify recommendations regarding accommodations for this student, and a rationale as to why these accommodations are warranted based upon the student's functional limitations. (Indicate why the accommodations you recommend are necessary.) _________________________________
   ____
   ____
   ____

Signature of Provider:_________________________________ Date:_________________________
License # ____ State:_________________________

Name/Title: ____
Address: ____
Phone: ____
E-mail: ____