



Student Accessibility Services (SAS)

580 East Main Street
Spartanburg, SC 29302
Office: 864.596.9027
Fax: 596-9146
www.converse.edu

Physical/Motor Disability

Student's Name: _____

To be completed by a Qualified Licensed Provider:

Converse University 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 requirements 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? _____



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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: _____
License # _____

Date: _____
State: _____

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