Disability Services Office, SC229 | 2740 West Mason St, Green Bay, WI 54303 | 920-498-6904 | Fax: 920-491-3792
disability.services@nwtc.edu

# DISABILITY DOCUMENTATION FORM

**(To be completed by a qualified medical doctor, psychiatrist, psychologist, counselor, or social worker)**

**Student Name:** _____

**(Please type or print neatly / use a separate paper if needed)**

1. **What is the diagnosis?** _____
2. **Level of severity:** **Mild** _____ **Moderate** _____ **Severe** _____
3. **When was the diagnosis made?** _____
4. **When was your last contact with the above-named student?** _____
5. **Is the condition:** **Temporary**_____ **Permanent** _____
6. **Please provide an explanation of the disability, medical condition, or symptoms:**

   _____

   _____
7. **If a treatment plan exists, what is the plan in brief?** _____

   _____

   _____
8. **Provide a description of the student's functional limitations as a result of this condition, and how they might impact on this student's academic activities (such as reading, writing, note-taking, concentration, studying, interactions with others… instructors and students, etc.)**

   _____

   _____

   _____

   _____

**Professional's Signature:** _____ **License #:** _____

**Print or type name and title:** _____

_____

**Address:** _____

**Phone:** _____ **Date:** _____