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## Documentation for a PSYCHOLOGICAL Disability

To be completed by the diagnosing professional, who should not be a relative of the student  
PLEASE PRINT

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Date of Initial Contact with Student: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Is the condition: \_\_\_\_\_Permanent? \_\_\_\_\_Temporary?

, what is the anticipated length of disability? \_\_\_\_\_

Briefly describe (print) the student's medical condition and physical limitations.

Diagnostic criteria/test used:

Treatments/medications/devices or resources currently prescribed (name of medication and dosage):

Expected duration, stability, or progression of the condition:

Is the student functionally impaired by one or more of the above listed conditions? \_\_\_\_Yes \_\_\_\_No

, specifically describe how the condition contributes to functional impairments or limitations in an educational setting and to what degree.

*Promoting Academic Excellence in a Christian Environment*

