GEORGIA HIGHLANDS COLLEGE

Dear Health Care Provider,

The Student Support Services Department of Georgia Highlands College coordinates services for students with disabilities as mandated by federal law. To receive services, students voluntarily register with SSS Disability Support. In order for a student to be considered for eligibility, the disability must result in substantial limitations to one or more major life activities. It is the student's responsibility to provide detailed documentation.

We request that you please help this student by furnishing as much of the following information as you may have available and as quickly as possible. Only documentation signed by a professional licensed to diagnose the particular disability can be accepted.

Thank you for helping us to enhance this student's opportunity for academic success. Please do not hesitate to contact SSS-DS for additional information.

Sincerely,

Student Support Services
Georgia Highlands College

Contact Information by Location:

Floyd, Marietta & Douglasville:
Maritza Pitelli, M. Ed, LPC
Disability Specialist
706-368-7536
mpitelli@highlands.edu

Cartersville & Paulding:
Kim Linek, MSW
Disability Specialist
678-872-8004
klinek@highlands.edu

Health Care Provider Form

Please complete this form legibly and thoroughly.

PATIENT/STUDENT NAME:_______________________________

1. What is the student's diagnosis, including diagnostic codes for each?

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2. What are the current symptoms and/or limitations as a result of the disability?

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3. What is the level of impairment? _____Mild _____ Moderate _____ Severe

Please elaborate on the level of impairment:

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4. What is the expected duration? _____ Chronic _____ Episodic _____ Short-term

Please elaborate on the expected duration:

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5. Please indicate how the impairments/limitations may affect or interfere with academic performance?

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6. List the student's current medication(s) and adverse side effects (if applicable for the above mentioned disorder).

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7. State <u>specific</u> recommendations regarding academic accommodations and/or other services that are warranted by the reported functional limitations measured in your professional evaluation.

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8. Additional Comments:

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HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and fill in all other fields completely using PRINT or TYPE)

Signature of Provider: __________________________ **Date:** _____________

Name (Print): ____

Title:____

License #: ____

Address: ____

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Phone: _________________________ **Fax:** ___________________________