STUDENT SUPPORT SERVICES

GHC

GEORGIA HIGHLANDS COLLEGE

Dear Healthcare 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 the SSS Disability Access Office. 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.

Guidelines for documentation can be found at: https://www.usg.edu/academic_affairs_handbook/section3/C793

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

Sincerely,
Student Support Services
Georgia Highlands College

Contact Information :

Disability Access Office
disabilityaccess@highlands.edu
706-295-6336

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Health Care Provider Form

Please complete this form legibly and thoroughly

Patient/Student Name: _____ DOB: _____

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

_____

_____

_____

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

_____

_____

_____

_____

3. What is the level of impairment? _____Mild _____Moderate _____Severe

   Please elaborate on the level of impairment:

_____

_____

_____

_____

4. What is the expected duration? _____Chronic _____Episodic _____Short-term

   Please elaborate on the expected duration:

_____

_____

_____

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

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

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

8. Additional Comments:

HEALTHCARE PROVIDER INFORMATION

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

Signature of Provider: _____ **Date:** _____

Provider Name (Print): _____

Title: _____ **License #:** _____

Address: _____

Phone: _____ **Fax:** _____