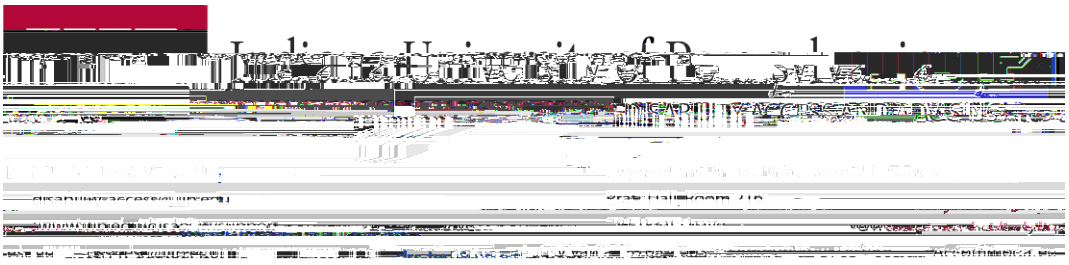

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9 This form exclusively used by DUS Students to provide do lÁH # .0 0 P)'P ™/0 Y" q5³ j`)'Ó ,È #™b™,ÁC # "™"™# ,"™o (

To Whom It May Concern:

A patient/client of yours has requested disability support services from the Department for Disability Access and Advising (DAS) at Indiana University of Pennsylvania. Legal protection and eligibility for these services is contingent on the student providing sufficient documentation that concludes he/she Z • v] u ‰] Œ u v š š Z š • µ • š v š] o o Ç o] u] š • } v } Œ u } Œ u i } Œ • š µ v š

Student Name: _____ Date of Birth: _____/_____/_____
First Middle Last

Diagnosis/Impairment:

When was this diagnosis originally made? _____/_____/_____

Is this student still under your care? YES NO

When did you last see this student? _____/_____/_____

Is the impairment temporary (<3 months) or persistent? _____

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Is the student taking any medication to treat the impairment? YES NO

If YES, does the medication have any effects on learning or functioning in a college setting (e.g., Indicate when the medication is most effective, side effects that affect learning, etc.)?

What methods were used to assess functional limitation? Please list or attach any supporting information to this form.