

## Documentation for Hearing Loss & Deafness

Kennesaw State University's Student Disability Services provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Disability Services will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in Disability Services. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

Please complete this form, fill out the Healthcare Provider Information section on the last page, sign it, then return it to the student, who will give it to the Disability Services Provider at Kennesaw State University.

---

Date of Birth

Print Name

Student ID#

*Please provide a copy of this individual's most recent audiogram.\**

**Primary Diagnosis:** \_\_\_\_\_

Date of onset: \_\_\_\_\_

**Secondary Diagnosis (if any):** \_\_\_\_\_

Date of onset: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Describe the history and status of hearing, and any symptoms or accompanying conditions.

---

---

---

---

---

Describe current functional limitations, which affect this student in the academic setting, and suggestions for accommodations (i.e., special seating, or captioned media).

**Limitations**

**Recommendations**

---

---

---

---

---

---

---



---

---

---

---

---

---

---

\*The audiogram should not be older than three (3) years from the date of request for services, unless the condition is of a permanent and non-varying nature.

**Healthcare Provider Information (In the space provided, please attach a business card.)**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Please print)*  
 \*\*Provider name: \_\_\_\_\_ Title: \_\_\_\_\_ License #: \_\_\_\_\_

Attach Business Card Here