KENNESAW STATE UNIVERSITY
DIVISION OF STUDENT AFFAIRS
Student Disability Services

Documentation for Systemic Conditions

Kennesaw State University's Student Disability Services provides support services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Student 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#

Primary Diagnosis: ____

Date of onset: ____

Secondary Diagnosis (if any): ____

Date of onset: ____

Date of last visit: ____

Describe the substantial limitations that affect this student's ability to conduct major life activities.

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Describe current functional limitations, which affect this student in the academic setting, and suggestions for accommodations (i.e., frequent breaks, extra time on tests).

Limitations	**Recommendations**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Describe the history, current symptoms, and severity of the condition.

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Describe the expected progression, prognosis or stability of the health condition(s). (Add pages if needed.)

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List current medications and explain how each affects the individual's limitations.

Medication/Dosage	**Impact on Limitations**
______________________	______________________
______________________	______________________
______________________	______________________

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

Website: https://sds.kennesaw.edu
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Marietta Campus Location: Joe Mack Wilson Student Center, Suite 160
Email: sds@kennesaw.edu
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