Appleton Campus
1825 N. Bluemound Drive, P.O. Box 2277
Appleton, WI 54912-2277
www.fvtc.edu

Disability Documentation Form

(To be completed by a qualified medical professional)

Student name and DOB: _____

What is the diagnosis? _____

When was the diagnosis made? _____

When was your last contact with the above-named student? _____

Is the diagnosis: Temporary_____ Permanent_____

Please provide an explanation of the disability, medical condition, and/or symptoms:

_____

_____

_____

What would be helpful for us to understand in the student's treatment plan?

_____

_____

Please provide a description of the student's functional limitations and how they may impact academic activities (such as reading, writing, note taking, concentration, studying with others, etc.)

_____

_____

_____

_____

Professional's signature: _____ License#:_____

Print name and title: _____

Address: _____

Phone: _____ Date: _____