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: ____

1. What is the diagnosis? ____
2. When was the diagnosis made? ____
3. When was your last contact with the above-named student? ______________________________
4. Is the diagnosis: Temporary__________ Permanent__________
5. Please provide an explanation of the disability, medical condition, and/or symptoms:

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

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7. 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.)

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Professional's signature: ______________________________ **License#:** ____________

Print name and title: ____

Address: ____

Phone: ______________________ **Date:** ______________________