CLAYTON STATE UNIVERSITY
Disability Resource Center

Documentation for Hearing Loss & Deafness

Clayton State University's Disability Resource Center provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. The Disability Resource Center 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 healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. All parts of this form must be completed as thoroughly and legibly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process for the student.

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 the Disability Resource Center. 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 needs.

After completing this form, sign it, complete the Healthcare Provider Information section on the last page and return it to the student, who will give it to the Disability Resource Center staff at Clayton State University.

To view the USG BOR disability documentation criteria, please visit the following website:
https://www.usg.edu/academic_affairs_handbook/section3/C793.

____________________	____	______________________________
Date	Student Name (Print)	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 current status of hearing, and any symptoms or accompanying conditions.

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

Limitations	**Recommendations**
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*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

Provider Signature: ____ Date: ____________________

Provider Name (Print): ____

Title: ____ License #: ___________________________

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