CLAYTON STATE UNIVERSITY
Disability Resource Center

Documentation for Brain Injuries (ABI/TBI)

Clayton State University's Disability Services provides academic services and accommodation 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 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 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 Disability Services 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#

Primary Diagnosis: _____

Date of onset: _____

Secondary Diagnosis (if any): _____

Date of onset: _____ Date of last visit: _____

Describe the functional/physical 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 (e.g. frequent breaks, extra time on tests).

Limitations	**Recommendations**

Describe the nature of the neurological illness or traumatic event that resulted in brain injury. Include the date or time period of occurrence.

Identify the objective measures and results related to functional impact of the brain injury (e.g. cognitive and academic skills, psychosocial-emotional functioning, and/or motor/sensory abilities).

HEALTHCARE PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____ License #: _____

[Attach Business Card Here]