Bladen Community College

Office of Disability Services

DISABILITY DOCUMENTATION & ACCOMMODATION FORM

Purpose of this form. This form is intended to assist Bladen Community College Disability Services in evaluating documentation of a disability and determining reasonable accommodations in the postsecondary educational environment.

The most useful documentation describes the student's current functional limitations and explains how those limitations affect access to college courses, programs, services, testing, communication, or other college activities.

Professional documentation should be completed by a qualified professional whose training, licensure, certification, or scope of practice is appropriate to the documented condition. Additional records may be requested when clarification of the student's current functional limitations or accommodation needs is necessary.

SECTION 1 — STUDENT INFORMATION

Student Full Name: _____	Student ID: _____
Date of Birth: _____	Date of Request: _____
Preferred Name (if different): _____	Program/Major: _____
Student Phone: _____	Student Email: _____

SECTION 2 — PROFESSIONAL DOCUMENTATION

Diagnosis / condition: _____	DSM-5 / ICD diagnosis or code, when applicable: _____
Date of Initial Diagnosis: _____	Date of Most Recent Evaluation: _____
Date of Most Recent Clinical Visit: _____	Date of Most Recent Testing: _____

Diagnostic / Evaluative Methods Used: _____

Please attach relevant supporting documentation when available, such as psychoeducational or psychological evaluations, neuropsychological reports, audiology reports, vision reports, medical records, or other documentation that provides information about the student's current functional limitations.

SECTION 3 — FUNCTIONAL LIMITATIONS

Please describe the student's current functional limitations related to the documented condition. Focus on functional impact rather than diagnosis alone. When applicable, describe how the condition affects the student's ability to access or participate in the following:

- Classroom instruction, participation, or attendance
- Reading, writing, mathematics, or other academic tasks
- Concentration, attention, memory, processing speed, or executive functioning
- Testing and examinations
- Communication or interaction with others
- Use of technology, instructional materials, or learning environments
- Other college-related activities or essential program requirements

Detailed description of current functional limitations and educational impact:

_____

_____

_____

SECTION 4 — DURATION, COURSE, AND PROGRESSION

Expected duration of the condition / functional impact:

☐ Temporary — anticipated recovery date: _____

☐ Permanent

☐ Chronic / Long-term

☐ Episodic / Recurring

☐ Variable / Fluctuating

☐ Other: _____

Expected progression or stability of the condition / functional impact:

_____

_____

SECTION 5 — RECOMMENDED ACCOMMODATIONS

Please identify accommodations that may reasonably address the functional limitations described above. For each recommendation, provide a brief explanation connecting the accommodation to the student's functional needs.

RECOMMENDATION 1

Accommodation: _____

Functional limitation / rationale:

_____

_____

RECOMMENDATION 2

Accommodation: _____

Functional limitation / rationale:

_____

_____

RECOMMENDATION 3

Accommodation: _____

Functional limitation / rationale:

_____

_____

ACCOMMODATIONS PREVIOUSLY USED, IF KNOWN

_____

_____

SECTION 6 — OTHER RELEVANT INFORMATION

Please provide any additional information relevant to the student's functional limitations, access needs, or recommended accommodations.

_____

_____

_____

SECTION 7 — PROFESSIONAL ATTESTATION

I certify that the information provided in this form is based upon my professional evaluation and/or treatment of the student and accurately reflects the student's current condition and functional limitations to the best of my professional knowledge. I understand that this documentation will be reviewed by Bladen Community College Disability Services for the purpose of evaluating the student's eligibility for reasonable accommodations.

Name of Diagnosing / Treating Professional: _____	License / Certification #: _____
Organization / Practice: _____	Area of Practice / Specialty: _____
Phone: _____	Date: _____

Signature: _____

CONFIDENTIAL STUDENT RECORD

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