

DOCUMENTATION OF DISABILITY

All documentation should be submitted as soon as possible to avoid delays in services.
Requests for accommodations are confidential and separate from the CVTC admissions process.

Student Name: _____ CVTC Student ID: @00 _____

Date of Birth: _____ Phone Number: _____

This Section To Be Completed By Appropriate Professional:

1.) Diagnosis, condition, or DSM-5 code: _____
_____ Date of diagnosis: _____

2.) Description of the severity of disability and current functional limitations related to daily life activities
such as: learning, reading, writing, seeing, hearing, walking, working, etc.: _____

3.) Medications and side effects or possible side effects such as: drowsiness, inattentiveness, etc., which
may influence the types of accommodations needed: _____

4.) Is the disability: (check box) Permanent Temporary: Duration: _____
Professional's Name (please print): _____ Title: _____
Clinic Name (please print): _____ Phone: _____
Professional's Signature: _____ Date: _____

Please attach supporting documentation such as testing or evaluation reports or an IEP if appropriate.

We may request additional information as needed.