Physician Form
Professional Documentation of Disability

Pocahontas Phone 870-248-4000 ext. 4014/Fax 870-248-4100
Paragould Phone 870-239-0969 ext. 5012/Fax 870-239-2050

*****This form is confidential and is to be completed by a physician or licensed professional. The purpose of this form is to assist BRTC Disability Services in providing accommodations to support the student in his/her academic career.**

Please include with this form a copy of your evaluation report concerning this student. Yes □ No □

Student Name: ______________________________ Date:_____________ SS#: _____________

Student's Address: ____

Date of the last examination: _______________ Diagnosis of Disability:___________________

Description of the Disabling Condition: ____

____

Do you consider this illness/disorder to be a disability? Yes □ No □

Do you consider this disability to be permanent? Yes □ No □

Please list specific recommendations: ____

____

Current functional limitations that may inhibit this student in the educational environment:

____

____

Information of the Physician or Professional below:

Physician/Professional's Name (print): ____

Title: ____ Phone Number: __________________

Address:____

____
Signature of Examining Physician or Professional   Date Signed

******Note: Signature must be the signature of a physician or professional.***

Rev. 2/23

As adapted from ASU Disability Services 09-03-13