



**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