



Certifying Professional Questionnaire

The proponent department is Disability Support Services

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PRINCIPAL PURPOSE: Evaluation of a student disability by a non-San Antonio College professional

ROUTINE USES: Used to evaluate and determine accommodations for a student in an academic setting

1. CLIENT/STUDENT NAME (LAST, FIRST)

2. DATE OF INITIAL DIAGNOSIS

3. DATE OF BIRTH

4. DISABILITY-RELATED DIAGNOSIS (MEDICAL OR DSM-V)

5. MEDICATION(S) PRESCRIBED

6. DATE LAST SEEN BY CERTIFYING PROFESSIONAL'S OFFICE RELATIVE TO THE DISABILITY IN QUESTION

7. DATE OF MOST RECENT PSYCHO-EDUCATIONAL OR DISABILITY-RELATED EVALUATION (NOT 504 PLAN OR IEP)

8. DOES THE DISABILITY CONSTITUTE A CURRENT AND SUBSTANTIAL LIMITATION OF A MAJOR LIFE ACTIVITY (I.E., LEARNING, WALKING, SPEAKING, HEARING, READING, WRITING, AND CONCENTRATING)

No Yes If yes, please indicate major life activity:

9. BRIEFLY DESCRIBE THE NATURE OF THE IMPACT OF THE DISABILITY ON THE STUDENT'S ABILITY TO LEARN IN A COLLEGE ENVIRONMENT

10. WHAT SUPPORT(S) IS THIS STUDENT LIKELY TO NEED FOR HIM/HER TO HAVE A FAIR AND EQUAL OPPORTUNITY TO LEARN (NOT WHAT IS MERELY HELPFUL) RELATIVE TO SAME-AGED, NON-DISABLED PEERS? (NOTE: SPECIFIC ACCOMMODATION WILL BE DETERMINED BY THE DISABILITY SUPPORT SERVICES OFFICE)



ALAMO COLLEGES DISTRICT
San Antonio College

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11. NAME

12. PRIMARY PHONE NUMBER

13. PROFESSIONAL TITLE

14. LICENSE NUMBER

15. SIGNATURE

16. DATE

EMAIL, FAX OR MAIL FORM TO

17. NAME

18. ORGANIZATION

19. ADDRESS

20. EMAIL

21. FAX

22. PHONE

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