ERSKINE
COLLEGE

Request for Academic Accommodations
Information from Physician or Other Licensed Health Care Provider

Patient/Student's Legal Name:_____ DOB:_____

The student above is requesting academic accommodations for a learning disability. Your diagnosis and recommendations will be provided to each professor teaching this student. This documentation will help guide each professor to determine the accommodations to provide to this student, as appropriate for the specific course and course material. The medical/health professional completing this form must not have significant personal ties to the student or the student's relatives beyond the patient-provider relationship.

Please provide the following information:

- Patient's diagnosis/disability: _____
- Present symptoms and effects of the diagnosis/disability: _____

  _____

  _____
- Tests Administered (date, score, percentile)/Score(percentile): _____

  _____
- Recommended Accommodations: _____

  _____

  _____
- Additional Considerations: _____

  _____

  _____

Professional's Name (Printed):_____ Date:_____

Professional's Signature:_____

Professional Credential (license):_____ License Number/State:_____

Practice Name: _____

_____

Address:_____

_____

Email: _____

Phone: _____

Attach supporting documentation: IEP, 504, testing paperwork. This form and any other relevant documentation may be given to the student or forwarded to

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