Georgia State University | DISABILITY SERVICES
DIVISION OF STUDENT AFFAIRS

Documentation for Autism Spectrum (Asperger's)

Georgia State University's Office of Disability Services provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Disability Services will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in Disability Services. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

After completing this form, sign it, complete the Healthcare Provider Information section on the last page and return it to the student, who will give it to the Disability Services Provider at Georgia State University.

Date _____ Print Name _____ Student ID# _____

Description of Diagnosis: _____

DSM/ICD code: _____ Date of last visit to this provider: _____

Date of original diagnosis: _____ Diagnosed by: _____

Describe cognitive ability as assessed using standardized assessment measures with age-appropriate norms. Identify assessment measures used and date. (Attach assessment reports if available.)

_____

_____

_____

Describe limitations that affect this individual's ability to conduct one or more major life activities.

_____

_____

_____

Describe the current limitations or impairments in social communication and interaction, and the degree of their impact on functioning. Include restricted or repetitive patterns of behavior, interests and activities and their impact in an academic environment.

_____

_____

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Describe current functional limitations, which affect this individual in the academic setting, and suggestions for accommodations (i.e., note taker, extra time on tests).

Limitations	**Recommendations**

Healthcare Provider Information (In the space provided, please attach a business card.)

Provider Signature_____ Date_____

(Please print)

**Provider name:_____ Title:_____ License #:_____

Attach Business Card Here

Alpharetta: alpcds@gsu.edu **Atlanta:** dismail@gsu.edu **Clarkston:** clacds@gsu.edu
Decatur: deccds@gsu.edu **Dunwoody:** duncds@gsu.edu **Newton:** newcds@gsu.edu