

FORM FOR DOCUMENTATION OF STUDENT DISABILITIES
Fielding Graduate University

This section to be completed by the student (please print or type):

Student Name: _____ ID#: _____

School: _____ Degree program: _____

Name of Physician/Healthcare Practitioner: _____

This section to be completed by health care professional (please print or type):

Diagnosis:

Present level of functioning:

Limitations related to specific life activities:

Prognosis:

I certify that that this diagnosis qualifies as a disability under the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

Physician Signature

Date

Type of practice/professional specialty

State/License #

Requests for accommodations must be submitted to: Director of Student Advising, Fielding Graduate University, 2112 Santa Barbara St., Santa Barbara, CA 93105. Requests for accommodations may also be sent by FAX to: 805-898-4107, or via e-mail to <accessability@fielding.edu>