Client Information:

_____

Client Name: Last, First, Middle Initial

Date of Birth: _____

& O L 6HWQXWG H Q W , '#: _____

Certifying Professional's Printed Name:_____

Credentials/Specialization:_____

License Type: _____

License #:_____ State _____ Exp. Date _____

Mailing Address:_____

City/State/Zip:_____

Phone: (_____)_____ Fax: (_____)_____

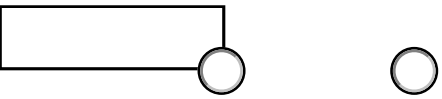
Email: _____

Office web address _____

[redacted]

Date of onset: _____ Date of diagnosis: _____

Diagnostic Tools:



[illegible]

Implications for Workplace or Academic/Student Life

Major Life Activity	Impacts [illegible]	Recommendations for Accommodations and Services [illegible]
Concentration		
Long-Term Memory		
Short-Term Memory		
Sleeping		
Eating		
Social Interactions		
Self-Care		
Managing Internal Distractions		
Managing External Distractions		

Using the contact information on page one, print, sign below, and fax/send directly to the Disability Support Resources office.

Date: B B B B B B B B B

Certifying Professional's Signature: B B B B B B _____

Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1