

Arkansas State University
Disability Services
Phone 870-972-3964/Fax 870-972-3351

Client Information Form

This form is Confidential and is to be completed by a physician or licensed professional.

Date: _____

The purpose of this form is to assist ASU Disability Services in providing accommodations to assist the student in his/her academic career.

Student Name: _____ SS # _____

Student Address: _____

Label and Describe the Disabling Condition: _____

Please include with this form a copy of your evaluation report concerning this student.

If you have specific recommendations, please list them below.

What is the date of the last examination? _____

Do you consider this condition to be a disability? Yes No

Do you consider this disability to be permanent? Yes No

Name and title of examining physician or professional: _____

Address and phone number of physician or professional: _____

Signature of Examining Physician or Professional

Date Signed

***Note: signature must be the original signature
of physician or professional.*