CLAYTON STATE UNIVERSITY
Disability Resource Center

Documentation for Autism Spectrum (Asperger's)

Clayton State University's Disability Resource Center provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. The Disability Resource Center 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 healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. All parts of this form must be completed as thoroughly and legibly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process for the student.

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 the Disability Resource Center. 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 needs.

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 Resource Center staff at Clayton State University.

To view the USG BOR disability documentation criteria, please visit the following website: https://www.usg.edu/academic_affairs_handbook/section3/C793.

_____ _____ _____

Date Student Name (Print) 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.)

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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.

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

Limitations	**Recommendations**

HEALTHCARE PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____ License #: _____

[Attach Business Card Here]