The Noel Center for Disability Resources (Noel Center) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (psychiatrist, psychologist, counselor, therapist, social worker, medical doctor, optometrists, speech-language pathologists etc.) in obtaining the specific information to evaluate eligibility for academic accommodations.

A. **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified, or licensed to diagnosis medical conditions.

B. **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

C. **The healthcare provider should attach any reports which provide additional related information** (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.

D. **The information you provide will be kept in the student’s file at the Noel Center, where it will be held strictly confidential.** This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student’s academic adjustment.

*If you have questions regarding this form, please call the Noel Center at 704-406-4270. Thank you for your assistance.*
STUDENT INFORMATION

(Please Print Legibly or Type)

First Name_____________________________ Middle __________  Last ________________________________
Date of Birth ______________________________ Last 4 Digits of SSN ________________________________

Status (check one)

Current Student ❑
Transfer Student ❑
Prospective Student ❑

Local phone (_______) - _______ - ____________       Cell phone (_______) - ________ -

Address (street, city, state and zip code)
_____________________________________________________________________________________________
_____________________________________________________________________________________________

If GWU Student, GWU E-mail address _________________________________________@gardner-webb.edu
E-mail address ________________________________________________________________

Important: After documentation is reviewed, the Noel Center will send an email notification to
the student’s GWU email account, (e.g. name.123@gardner-webb.edu), acknowledging receipt of
documentation and the eligibility status.

DIAGNOSTIC INFORMATION
(Please Print Legibly or Type)

1. Date of Diagnosis __________________________________________________________________________
2. Primary Diagnosis __________________________________________________________________________
Secondary Diagnosis __________________________________________________________________________

3. What is the severity of the disorder? ❑ Mild       ❑ Moderate       ❑ Severe

4. Please state the medication or treatment the student is currently prescribed: _______________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
5. **Major Life Activities Assessment:**
Please check which of the following major life activities listed below are affected because of the impairment. Indicate severity of limitations.

<table>
<thead>
<tr>
<th>LIFE ACTIVITY</th>
<th>NEGLIGIBLE</th>
<th>MODERATE</th>
<th>SUBSTANTIAL</th>
<th>DON’T KNOW</th>
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<tbody>
<tr>
<td>Concentrating</td>
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<td>❏</td>
<td>❏</td>
<td>❏</td>
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<tr>
<td>Memory</td>
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<td>❏</td>
<td>❏</td>
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<tr>
<td>Eating</td>
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<tr>
<td>Social Interactions</td>
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<tr>
<td>Self-Care</td>
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<tr>
<td>Regular Class Attendance</td>
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<td>❏</td>
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<tr>
<td>Speaking</td>
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<tr>
<td>Managing External Distractions</td>
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<tr>
<td>Sleeping</td>
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<tr>
<td>Organization</td>
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</tr>
</tbody>
</table>
6. In addition to the major life activities affected that are indicated above, please describe any activities that may be impacted by the disability or symptoms that may need to be addressed in the college environment:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

7. Please state specific recommendations regarding academic accommodations for this student:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

8. Please add any additional comments that you feel appropriate:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and completely fill in all other fields using PRINT or TYPE)

Provider Signature ___________________________________  Date ________________________________

Provider Name (Print)  _________________________________________________________________________

Title  ________________________________________________________________________________________

License or Certification #  ________________________________________________________________________________________

Address  _______________________________________________________________________________________

_____________________________________________________________________________________________

Phone Number (_____ _____ - ________

Fax Number (___ ) ______-_________