

Date of Last Visit: _____

Glasses Prescribed: Yes: _____ No: _____

Magnification Aids Prescribed: Yes: _____ No: _____

Braille and Audio Required: Yes: _____ No: _____

III. Current Impact

In the space below please provide a summary of how the disability will impact the student in the educational environment (i.e., limitations/restrictions, strategies for achieving equal access, etc.). Which services, if any, do you recommend?

NOTE: This is for informational purposes only. If required, Guilford Technical Community College will determine the appropriate services.

Thank you for your cooperation in this matter. Your prompt attention will allow us to begin providing services as soon as possible. Incomplete or missing information can prevent or delay necessary services. This form must be completed and signed by the qualified professional who performed the evaluation and made the diagnosis.

Professional Credential Documentation (PLEASE ATTACH YOUR BUSINESS CARD TO THE DOCUMENT OR ANOTHER FORM OF IDENTIFICATION FOR THE STUDENT FILE.)

Name _____

Address _____

Title _____

Professional Credentials _____ Phone : _____

License/Certification number _____

Signature _____ Date _____

To expedite the process, you may fax a copy to **1-336-232-9803**. All documentation is confidential. In addition to faxing, please mail the signed, original form to:

Guilford Technical Community College:

disAbility Access Services

P.O. Box 309

Jamestown, NC 27282

Attention: _____