

**DOCUMENTATION OF TEMPORARY CONDITION**

Students requesting services for a temporary condition at NC State University must provide current documentation.

As the diagnosing professional, please **fully complete all sections of this form**. Additional reports, information, or narrative can be attached if appropriate.

**Please note:** All information that you provide may be shared with this student unless clearly marked otherwise. Thank you for your assistance.

**Disability Services Office**  
Student Health Center Building  
2815 Cates Ave., Suite 1900  
Campus Box 7509  
Raleigh, NC 27695-7509

919.515.7653 (voice)  
919.515.8830 (TDD)  
919.513.2840 (fax)

www.ncsu.edu/dso

**To Be Completed By The Student    RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby authorize the release of the following information to the Disability Services

Student Name - Please Print

Office at NC State University for the purpose of determining my eligibility and services.

\_\_\_\_\_ Date

\_\_\_\_\_ Student's Signature

**Only To Be Completed By The Diagnosing Professional**

**Student Name:** \_\_\_\_\_

**I. Diagnosis**

**Primary Diagnosis** \_\_\_\_\_ **Code** \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_ Date of Last Evaluation \_\_\_\_\_

What is the expected duration? \_\_\_\_\_

**Secondary Diagnosis** \_\_\_\_\_ **Code** \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_ Date of Last Evaluation \_\_\_\_\_

What is the expected duration? \_\_\_\_\_

**Other Diagnosis** \_\_\_\_\_ **Code** \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_ Date of Last Evaluation \_\_\_\_\_

What is the expected duration? \_\_\_\_\_

**II. Treatment**

Date of Last Visit: \_\_\_\_\_ How often do you provide treatment? \_\_\_\_\_

Other Providers and frequency? \_\_\_\_\_

\_\_\_\_\_

**Prescribed Medications**

**Side Effects**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **III. Limitations/Restrictions**

List below the limitations/restrictions caused by the medical condition, how often the limitations/restrictions occur, how long they last, and the severity of each. (e.g. difficulty walking, daily, 24 hrs., moderate severity; no use of dominant hand, daily, 24 hours)

Restrictions/Difficulties

Frequency/Duration  
(daily, weekly, monthly/# hours, days, etc.)

Severity  
(mild, moderate, severe)

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Which services, if any, do you recommend? (This is for informational purposes only. If required, NC State University will determine the appropriate services.)

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Thank you for your help in providing this information so that we may 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.

**Please mail the signed original form. To avoid delay, also fax us a copy to 919-513-2840.**

**PLEASE ATTACH YOUR BUSINESS CARD TO THE DOCUMENT OR ANOTHER FORM OF IDENTIFICATION FOR THE STUDENT FILE.**

Name \_\_\_\_\_

Title \_\_\_\_\_

Business Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-Mail \_\_\_\_\_

Professional Credentials \_\_\_\_\_

License / Certification number \_\_\_\_\_

Area of Specialization \_\_\_\_\_

State / Province of Licensure / Certification \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_