ALAMO COLLEGES DISTRICT
Palo Alto College

Certifying Professional Questionnaire

The proponent department is Disability Support Services

THIS FORM IS PROTECTED UNDER THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974

PRINCIPAL PURPOSE: Evaluation of a student disability by a non-Palo Alto College professional
ROUTINE USES: Used to evaluate and determine accommodations for a student in an academic setting

1. CLIENT/STUDENT NAME (LAST, FIRST)	2. DATE OF INITIAL DIAGNOSIS	3. DATE OF BIRTH

4. DISABILITY-RELATED DIAGNOSIS (MEDICAL OR DSM-V)

5. MEDICATION(S) PRESCRIBED

6. DATE LAST SEEN BY CERTIFYING PROFESSIONAL'S OFFICE RELATIVE TO THE DISABILITY IN QUESTION

7. DATE OF MOST RECENT PSYCHO-EDUCATIONAL OR DISABILITY-RELATED EVALUATION (NOT 504 PLAN OR IEP)

8. DOES THE DISABILITY CONSTITUTE A CURRENT AND SUBSTANTIAL LIMITATION OF A MAJOR LIFE ACTIVITY (I.E., LEARNING, WALKING, SPEAKING, HEARING, READING, WRITING, AND CONCENTRATING)

☐No ☐ Yes If yes, please indicate major life activity:

9. BRIEFLY DESCRIBE THE NATURE OF THE IMPACT OF THE DISABILITY ON THE STUDENT'S ABILITY TO LEARN IN A COLLEGE ENVIRONMENT

10. WHAT SUPPORT(S) IS THIS STUDENT LIKELY TO NEED FOR HIM/HER TO HAVE A FAIR AND EQUAL OPPORTUNITY TO LEARN (NOT WHAT IS MERELY HELPFUL) RELATIVE TO SAME-AGED, NON-DISABLED PEERS? (NOTE: SPECIFIC ACCOMMODATION WILL BE DETERMINED BY THE DISABILITY SUPPORT SERVICES OFFICE)

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11. NAME	12. PRIMARY PHONE NUMBER
13. PROFESSIONAL TITLE	14. LICENSE NUMBER
15. SIGNATURE	16. DATE

EMAIL, FAX OR MAIL FORM TO

17. NAME	18. ORGANIZATION
19. ADDRESS	
20.EMAIL	
21. FAX	22. PHONE

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