Wentworth Institute of Technology

Disability Services

550 Huntington Ave
Boston MA 02115
phone: (617) 989 – 4390
fax: (617) 989 – 4571
www.wit.edu/wellness

Student Last Name: ____________________
Student First Name: ____________________
Student W#: __________________________

Wentworth Institute of Technology requires submission of documentation for students requesting accommodations. Students must submit a current diagnosis (within the last three years) by a licensed health professional (psychiatrist, clinical psychologist, neuropsychologist, or diagnosing physician). Please have your licensed health professional fill out the form below and attach any appropriate supplemental documentation.

Diagnosis

Primary diagnosis based on DSM-IV-TR criteria.

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Date of establishment: ___________________________ Date of last evaluation: _________________________

Describe any events which resulted in the diagnosis: ____

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History

Please discuss the student's history including the age when first diagnosed, any prior treatment and any relevant school information.

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Assessment

Please describe the student's present symptoms that meet the criteria for diagnosis. Also include any relevant test scores.

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Impact of Diagnosis and Recommendations

Describe the severity with which the disability and any related treatment(s) may impact the student's functioning in a post-secondary environment (academically, socially, and residentially).

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Is the student currently on any medications that will impact their ability to meet the demands of the post-secondary environment? If yes, please describe.

Please discuss the patient's current status and any psychosocial stressors.

Please provide a list of appropriate accommodation recommendations. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation.

Other comments:

EVALUATOR: ______________________________

Name / Title / License Number

ADDRESS: ______________________________

Street Name and Number

____

City / State / ZIP Code

PHONE NUMBER: ____________________ **FAX NUMBER:** ____________________

SIGNATURE: ____________________ **DATE:** ____________________