Wentworth Institute of Technology

CENTER FOR WELLNESS

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

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 medical professional (physician, specialist, surgeon, etc). Please have your licensed medical professional fill out the form below and attach any appropriate supplemental documentation.

DIAGNOSIS

Primary diagnosis.

_____

Date of establishment: _____ Date of last evaluation: _____

Describe student's current medical condition: _____

_____

_____

_____

HISTORY

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

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_____

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_____

ASSESSMENT

Please describe the student's present symptoms.

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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.

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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.

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Other comments:

_____
_____
_____
_____
_____

EVALUATOR: _____
Name Title License Number

ADDRESS: _____
Street Name and Number

_____
City State ZIP Code

PHONE NUMBER: _____ **FAX NUMBER:** _____

SIGNATURE: _____ **DATE:** _____