FUTURE PROFESSIONAL INFORMATION
(to be completed by Future Professional)

First Name: _____ Last Name: _____

Status (check one): __Currently Enrolled __Transfer ___ Prospective Future Professional

Phone: (_____) _____-_____ Email: _____

I authorize the following individual or organization to release the information included in this document to the ADA Compliance Coordinator at Shearz Institute:

Name/Title: _____ Phone: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Future Professional Signature: _____ Date: _____

DIAGNOSTIC INFORMATION
(to be completed by medical practioner/specialist)

- Please specify the specific diagnosis/disability. For psychological disabilities, please indicate both the name of the diagnosis and the diagnostic taxonomy that was used.

_____
_____
_____

Diagnostic taxonomy used: __ DSM (IV-TR or 5) ___ ICD (9 or 10)

If applicable, please rate the level of severity of the Future Professional's diagnosis:
___Mild ____Moderate ____Severe
Duration of condition: ____Permanent ___Temporary (specify length of time): _____

- How did you arrive at your diagnosis? Please check all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

___Behavioral Observation/Development History

___Medical History

___ Rating Scales (e.g., CAARS, Brown ADD Scales for Adults)

___Neuro-Psychological Testing, Date(s) of Testing _____

___Psycho-Educational Testing, Date(s) of Testing _____

___Structured/Unstructured Future Professional Interviews

___Other (please specify): _____

Please indicate the level of impact the Future Professional's disability may have in limiting the following major life activities:

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	N/A
Attending class regularly					
Caring for oneself					
Communicating					
Concentrating					
Hearing					
Interacting with others					
Interacting socially					
Learning					
Making/keeping appointments					
Managing distractions					
Managing stress					
Meeting deadlines					
Memorizing					
Organization					
Performing manual tasks					
Reading					
Seeing					
Sleeping					
Thinking					
Writing					
Other:_____					
Other:_____					
Other:_____					

-For the major life activities checked on the previous page, please provide an explanation of the functional impact of the limitation in an academic setting.

_____
_____
_____
_____
_____
_____

1 If applicable, please describe the relevant history of remediation (e.g., current medications, side effects of medications, other treatment plans and their effectiveness).

_____
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4 Please list any recommendations for accommodations you have for this Future Professional in an academic setting, if applicable. (Please note, recommendations will be considered in the interactive process; however, final decisions will be determined by School staff.)

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2 Please provide any additional information that you think would be useful to know in working with this Future Professional.

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_____

HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the Future Professional's record, subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the Future Professional upon written request.

Provider Name (print): _____
Provider Signature: _____Date: _____
Title: _____ License or Certification #:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____-_____ Fax: (_____) _____-_____

Please mail, email, PS, BOE, EFMJWFS this completed form to:
ADA Compliance Coordinator Carmen Murphy at Paul Mitchell The School Atlanta
887 West Mariette St. NW, Suite A, Atlanta, GA 30318
Phone: (404) 888-0070 • Email: carmen@atlanta.paulmitchell.edu