Exceptional SC Third Party Designation
Proof of Eligibility Medical Professional Form

This form should be completed by a medical professional. Mail this form attached to the scholarship application to: Exceptional SC, PO Box 211847, Columbia, SC 29221. For online applications, upload and attach the completed form to the Exceptional SC online application.
***Please note**: For the 2016-2017 application year, Exceptional SC will accept medical professional forms previously accepted by SFOs as long as the eligibility determination date is within the past three years.*

Student's Full Name: _____

Date of Birth: _____

Proviso 109.15 defines an "exceptional needs child" as a child:

- (a) who has been evaluated in accordance with this state's evaluation criteria, as set forth in S.C. Code Ann. Regs. 43-243.1, and determined eligible as a child with a disability who needs special education and related services, in accordance with the requirements of Section 300.8 of the Individuals with Disabilities Education Act; or
- (b) who has been diagnosed within the last three years by a licensed speech-language pathologist, psychiatrist, or medical, mental health, psychoeducational, or other comparable licensed health care provider as having a neurodevelopmental disorder, a substantial sensory or physical impairment such as deaf, blind, or orthopedic disability, or some other disability or acute or chronic condition that significantly impedes the student's ability to learn and succeed in school without specialized instructional and associated supports and services tailored to the child's unique needs.

By signing below, I am affirming:

(1) I am a licensed speech-language pathologist, psychiatrist, or medical, mental health, psychoeducational, or other comparable licensed health care provider.
Licensed health care provider type: _____

(2) I diagnosed the above named student on _____ *(most recent date within three years)* as having a neurodevelopmental disorder, a substantial sensory or physical impairment (deaf, blind, or orthopedic disability), or some other disability or acute or chronic condition that significantly impedes the student's ability to learn and succeed in school without specialized instructional and associated supports and services tailored to the student's unique needs.
Disability type: _____

Additional notes or details *(optional)*: _____
_____
_____

_____ _____
Professional's Name *(print)* Title

_____ _____
Professional's Signature Date