Verification of Physical Disability and Functional Limitation Due to Medical Condition

The student named below has applied for disability services through Student Services at Bellin College. In order to provide reasonable and appropriate services for students with disabilities, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist clinicians in providing sufficient information so that eligibility for services can be determined. The information which you provide will not become a part of the student's educational records and will be kept in the student's confidential file in the office of the Advisor in Student Services. In addition to the requested information, please attach any additional information; for example, your report and any test results. Thank you for your assistance.

Name of Student: _____Today's date: _____

1. Date of diagnosis/impairment: _____
2. Is the patient/student currently under your care? _____
3. When did you last see patient/student? _____
4. Major life activities assessment:

   Please check which of the major life activities listed on this page that are affected because of the impairment. Please indicate level of limitation:

Life Activity	1=Negligible	2=Moderate	3=Substantial
Talking	( )	( )	( )
Hearing	( )	( )	( )
Breathing	( )	( )	( )
Standing	( )	( )	( )
Working	( )	( )	( )
Reaching	( )	( )	( )
Lifting	( )	( )	( )
Sitting	( )	( )	( )
Walking	( )	( )	( )
Seeing	( )	( )	( )
Writing	( )	( )	( )
Performing manual tasks	( )	( )	( )
Sleeping	( )	( )	( )
Learning	( )	( )	( )
Reading	( )	( )	( )
Thinking	( )	( )	( )
Concentrating	( )	( )	( )
Memorizing	( )	( )	( )
Interacting with others	( )	( )	( )
Other: _____	( )	( )	( )

5. What are the specific functional limitations resulting from the impairment's impact on the major life activities identified above (i.e. unable to lift more than 10 lb; unable to keyboard more than 10 minutes out of 60 minutes)?

6. Are these limitations permanent? If not, what is the anticipated date of resolution?

7. Medications, effects and possible side-effects:

8. If patient/student is still undergoing treatment, please describe the treatment and how treatment may affect the student in the college setting.

9. Please indicate which accommodation, if any, may be beneficial to this student:

   ( ) Distraction-free environment
   ( ) Extended test time __15minutes __Time and one-half __Double time
   ( ) Note taking support
   ( ) Tape recorded textbooks
   ( ) Reduced credit load
   ( ) Enhanced audio technology
   ( ) Other: _____

10. Is there anything else that you would like us to know about this student?

Signature of medical doctor or other professional providing this information is required

Physician's name: _____ License # _____

Address: _____ Phone: ( ) _____

Signature _____

Please return this form to: Bellin College
Attn: Janelle Maricque
3201 Eaton Road
Green Bay, WI 54311

(Adapted from the University of Wisconsin-Green Bay Office of Disability Services)