

Policy Appendix

Part III--Documentation of Jisability-Related Need for an Accommodation Page 1 of 2

Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses. Date of Initial contact with student:	Last Name:	First Name:	MI:
Certifying Professional Statement: The named individual above is requesting accommodations based on the impact of a disability. To evaluate the request, the following form must be completed by a qualified professional licensed physician who is experienced in diagnosing the specific disability, who has first-hand knowledge of the individual's condition and is not related to the individual. Diagnosis Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses. Date of Initial contact with student: Date of Diagnosis: By: Diagnosis/es: Diagnosic Criteria/test Used: Expected duration: Permanent Chronic/recurring Temporary Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Date of Birth:	Phone:	
on the impact of a disability. To evaluate the request, the following form must be completed by a qualified professional licensed physician who is experienced in diagnosing the specific disability, who has first-hand knowledge of the individual's condition and is not related to the individual. Diagnosis Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses. Date of Initial contact with student: Date of Diagnosis: By: Diagnosis/es: Diagnosic/es: Diagnostic Criteria/test Used: Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	This section is to be con	npleted by a qualified prof	essional
pualified professional licensed physician who is experienced in diagnosing the specific disability, who has first-hand knowledge of the individual's condition and is not related to the individual. Diagnosis Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses. Date of Initial contact with student: Date of Diagnosis: By: Diagnosis/es: Diagnosic Criteria/test Used: Expected duration: Permanent Chronic/recurring Temporary Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Certifying Professional Statement	:: The named individual above is req	uesting accommodations based
who has first-hand knowledge of the individual's condition and is not related to the individual. Diagnosis Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses. Date of Initial contact with student: Date of Diagnosis: By: Diagnosis/es: Diagnostic Criteria/test Used: Describe the condition: Mild Moderate Severe Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	on the impact of a disability. To e	valuate the request, the following for	rm must be completed by a
Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses. Date of Initial contact with student: Date of Diagnosis: Diagnosis/es: Diagnostic Criteria/test Used: Devel of severity of the condition: Mild Moderate Severe Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	qualified professional licensed ph	ysician who is experienced in diagn	osing the specific disability,
Please attach any assessment reports and/or scores from any diagnostic tests that were used to support these diagnoses. Date of Initial contact with student:	who has first-hand knowledge of	the individual's condition and is not	related to the individual.
Date of Initial contact with student: Date of Diagnosis: Date of Diagnosis: Diagnosis/es: Diagnostic Criteria/test Used: Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Diagnosis		
Date of Initial contact with student:	Please attach any assessment re	eports and/or scores from any diagn	ostic tests that were used to
Date of Diagnosis:	support these diagnoses.		
Diagnosis/es: Diagnostic Criteria/test Used: Diagnostic Criter	Date of Initial contact with studen	t: Date of la	ast contact with student:
Diagnostic Criteria/test Used: Level of severity of the condition: Mild Moderate Severe Expected duration: Permanent Chronic/recurring Temporary Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Date of Diagnosis:	By:	
Level of severity of the condition: Mild Moderate Severe Expected duration: Permanent Chronic/recurring Temporary Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Diagnosis/es:		
Expected duration: Permanent Chronic/recurring Temporary Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Diagnostic Criteria/test Used:		
Expected duration: Permanent Chronic/recurring Temporary Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the			
Describe the current impact of the condition, particularly as it relates to academics/work: What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Level of severity of the condition:	Mild Modera	te Severe
What major life activity (e.g., walking, seeing, hearing, breathing, self-care) does the	Expected duration: Per	manent Chronic/recurri	ng Temporary
	Describe the current impact of	the condition, particularly as it re	elates to academics/work:
			, self-care) does the

Created: May 8, 2015



Policy Appendix

Part III--Documentation of

Disability-Related Need for an Accommodation

Page 2 of 2

Certifying Professional Statement--continued

Treatments/medications/devices or resources currently prescribed (name of medication and dose) and their potential impact on academic/work:		
commended accommodations (be specific):		
scribe how the recommendation impacts the condition:		
ernative recommendations:		
ease provide any additional information you believe would be helpful. Attach additional eets as necessary and include results of related assessments. me and Professional Title:		
ense/Certification Number:		
uing State:		
dress:		
y/State/Zip Code:		
one Number:		
gnature: Date:		

Return to:

Darla Dolph, MS, Academic Support and Career Services Coordinator Phone: 303-369-5151 x 231, Email: darla.dolph@plattcolorado.edu Platt College 3100 South Parker Road, Aurora, CO 80014

Created: May 8, 2015