Last Name: ________________________ First Name: ________________________ MI: ___________

Date of Birth: ______________________ Phone: ________________________

This section is to be completed by a qualified professional

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 last contact with student: ___________

Date of Diagnosis: ______________________________ By: ________________________________

Diagnosis/es: ____

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 condition substantially limit? ____

____

Certifying Professional Statement--continued

Treatments/medications/devices or resources currently prescribed (name of medication and dose) and their potential impact on academic/work: ______________________________

____

Recommended accommodations (be specific): ______________________________

____

Describe how the recommendation impacts the condition: ______________________________

____

Alternative recommendations: ______________________________

____

Please provide any additional information you believe would be helpful. Attach additional sheets as necessary and include results of related assessments.

Name and Professional Title: ______________________________

License/Certification Number: ______________________________

Issuing State: ______________________________

Address: ______________________________

City/State/Zip Code: ______________________________

Phone Number: ______________________________

Signature: ______________________________ Date: ______________________________

Return to:

Darla Dolph, MS, Academic Support and Career Services Coordinator
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