

UNIVERSITY OF WISCONSIN-GREEN BAY
DISABILITY SERVICES OFFICE

2420 Nicolet Drive, Student Services 1700, Green Bay WI 54311
Tel: (920) 465-2841 Fax: (920) 465-2191

CERTIFICATION OF VISUAL, HEARING, AND/OR OTHER HEALTH IMPAIRMENTS

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide **current** documentation of their disability. This documentation should provide information regarding the onset and severity of the disability, as well as describe how it interferes with educational achievement. In order to establish that an individual is covered under ADA and Section 504 of the Rehabilitation Act of 1973, documentation must demonstrate that the individual has a disability and that it substantially limits some major life activity, including learning. The documentation must show how the disability impacts the major life activity of learning, and if you are requesting accommodations, academic adjustments and/or auxiliary aids, the documentation must support your request.

The following form should facilitate this information gathering. Please complete this form in its entirety and attach appropriate medical reports if available. Appropriate services will be determined based on the specific information provided.

Please submit the completed form and/or evaluation reports to the University of Wisconsin-Green Bay.

Student Name _____ **Date** _____

1. Medical Diagnosis: _____

2. Date of most recent medical evaluation: _____

3. Severity of Disability: _____

4. Assessment procedures or evaluation instruments used to make this diagnosis, including

results:

a. _____

b. _____

c. _____

5. Disability related needs, including specific recommendations for academic accommodations, adjustments and/or auxiliary aids at the post-secondary level. The information provided in this section will be used in determining what accommodations are appropriate.

- a. _____

- b. _____

- c. _____

6. Describe any medication side-effects that may be anticipated:

7. Describe the prognosis and anticipated duration of the limitations described above:

Please attach any additional assessment information that might be helpful in providing appropriate accommodations, i.e. evaluations done by a speech pathologist, neuropsychologist, occupational therapist, physical therapist, etc. Thank you for your help in providing this information so that we may begin providing services as soon as possible. Please return this form to the address shown the letterhead.

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

Physician's Name _____ License # _____
(or other professional) Please Print

Address _____ Phone _____

Signature _____