

UNIVERSITY OF WISCONSIN-GREEN BAY

Disability Services Office

2420 Nicolet Drive, Student Services 1930, Green Bay, WI 54311
Tel: (920) 465-2841 Fax: (920) 465-2954

Certification of Physical Disability and Functional Limitation Due to Medical Condition

Dear Medical Professional: The student named below has applied for services from the Disability Services (DS) Office at UWGB. 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 you provide will not become part of the student's educational records and will be kept in the student's confidential file at DS Office. In addition to the requested information, please attach any additional information; for example, your report and any test results. Thank you for your assistance.

Date: _____

Name of Student: _____

1. What is the diagnosis/impairment: _____
2. Date of diagnosis/impairment: _____
3. Is the patient/student currently under your care? _____
4. When did you last see the patient/student: _____
5. Major Life Activities Assessment:

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

Life Activity	1 – Negligible	2 – Moderate	3 – Substantial
Talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memorizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interacting with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for Oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. 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)?

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

8. Medications, effects, and possible side-effects:

9. If student is currently undergoing treatment, please describe the treatment and how treatment may affect the student in a post-secondary setting.

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

- Distraction-free environment
- Extended test time
- Notetaking support
- Tape recorded textbooks
- Reduced credit load
- Other

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

Signature of Professional

Date

Medical Professional's Name (printed) and Title

License No.

Address

Telephone No.

Address

Fax No.