DISABILITY CERTIFICATION FORM

Dear ______________________________,

Physician/Clinician/Licensed Credentialed Professional

I am registering to receive Disability Services from the Office of Student Affairs which will allow me to receive appropriate accommodations and academic adjustments as needed for my diagnosed disability. I am, therefore, asking you to please certify my disability diagnosis and its duration, and the limitations that it places upon my abilities. Thank you for your immediate response to this request,

_________________________________________  ____________________________  ______
STUDENT NAME                        STUDENT SIGNATURE          Date

1. DSM-5/Medical Diagnosis:

2. Date of Diagnosis

3. Date of last contact with student:

4. Please describe the likely duration of this disability:

5. Please describe the current symptoms of this condition and the current treatment plan:

6. What major life activity/activities does this condition impact?

7. Please list current medications and potential side effects.

8. Describe current limitations that have a substantially impact the student’s ability to function in the college environment.

9. Are there any recommendations for this student that you can offer regarding accommodations or strategies that can assist the student with functioning in the educational environment:

Please attach relevant diagnostic test results, and any other information that can help to determine appropriate accommodations.