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Verification of Physical Disability/Medical Condition

The student named below has applied for services from the Special Needs Department at Gateway Technical College. In order to provide reasonable and appropriate services, current and comprehensive information regarding the functional impact of the disability is required. This form is intended to provide the Special Needs staff with sufficient information so that eligibility for services and appropriate accommodations can be determined. The information you provide is confidential and will not become part of the student's education record. In addition to the requested information, please attach any additional information you deem appropriate. Thank you for your assistance.

1. Name of student: _____ Date of Birth:_____
2. Date of your last contact with student: _____
3. Diagnosis(es):

   _____

   _____
4. Expected duration of condition: _____
5. Please list any medications that have been prescribed for this student:

Medication:	Possible Side-Effects:
_____	_____
_____	_____
_____	_____

6. Please identify all relevant activities that are affected by the impairment and indicate the severity of the limitation.

   1 = Negligible 2 = Moderate 3 = Substantial 4 = Severe

Talking	1	2	3	4
Walking	1	2	3	4
Hearing	1	2	3	4
Breathing	1	2	3	4
Reaching	1	2	3	4
Lifting	1	2	3	4
Sitting	1	2	3	4
Standing	1	2	3	4
Seeing	1	2	3	4
Writing	1	2	3	4
Dexterity	1	2	3	4
Sleeping	1	2	3	4
Reading	1	2	3	4
Information Processing	1	2	3	4
Concentrating	1	2	3	4
Memorizing	1	2	3	4
Other_____	1	2	3	4

7. Are there any specific restrictions or limitations resulting from the impairment on the major life activities mentioned above (i.e. unable to lift more than 10 lbs, read small print, stand for prolonged periods of time, unable to keyboard more than 10 min out of 60 min, etc)?

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

9. Please describe functional limitations this student encounters when using medication.

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

_____ _____

Signature of Professional Date

_____ _____

Medical Professional's Name and Title (printed) License Number

_____

Address City State Zip

_____ _____

Telephone Number Fax Number