MEDICAL DISABILITY VERIFICATION FORM

To be used for Mobility Limitations and/or Perceptual Limitations such as Visual, Hearing and other Health Impairments or Chronic Illness

SECTION I - To be completed by the student:

Name: _____ Student ID#:_____

Address: _____

Phone: _____ Date of Birth: _____

Physician or Appropriate Professional: _____

Phone: _____ FAX: _____

Address: _____

I authorize the release of the information requested on this Disability Verification Form to the Disability Services Office at Wharton County Junior College.

Student Signature: _____ Date: _____

SECTIONS II & III - To be completed by physician or other certifying professional:

A. COMPLETE FOR YOUR PATIENT/CLIENT WITH MOBILITY LIMITATIONS:

What restrictions does this individual have regarding the length of time engaged in:

Sitting: _____ Writing: _____ Walking: _____

Functional limitations which may require alterations to traditional classroom seating, lab/work station, library research, etc.:

_____

_____

B. COMPLETE FOR YOUR PATIENT/CLIENT WITH PERCEPTUAL LIMITATIONS:

Visual Impairment: Visual Acuity Left _____ Right _____

Field Left _____ Right _____

Comments:_____

Hearing Impairment: dB Loss (Please use current audiogram) Left _____ Right _____

Comments: _____

PLEASE SEE BACK OF PAGE FOR YOUR SIGNATURE AND ADDITIONAL DISABILITY CATEGORIES.

DISABILITY VERIFICATION - PAGE 2:

SECTION III. Complete for All Patients/Clients:

A. Diagnosis: _____ Prognosis: _____

This disability is: (check one) [ ] Permanent [ ] Temporary

If temporary, disabling condition is expected to last:

_____weeks _____ days _____months

B. Briefly describe the functional limitations of the disability, effect of medications, etc., on ability to meet class and/or program requirements.

_____

_____

C. Name of certifying professional (please print):_____

Title: _____ Certification or license #: _____

Address: _____ Phone: _____

I verify that the above information is complete and accurate to the best of my knowledge.

Signature of physician or appropriate professional: _____

Date: _____