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's Name: ____

I authorize the release of the information requested on this Medical Disability Verification Form to WCJC Disability Services Office.

Student Signature: ____________________________ Date: __________________

SECTIONS II - To be completed by physician:

Name of Physician (please print): ____

Certification or license #: ________________ Phone: ________________________

Practice Address: ____

E-mail: ____

A. What are the diagnoses? ____

B. How do these diagnoses affect the patient's ability to access the learning environment?

____

____

Visual Impairment: (circle one) Yes No

Visual Acuity: Left __________ Right __________ Field Left __________ Right __________

Hearing Impairment: (circle one) Yes No

dB Loss (Please use current audiogram) Left ____________ Right __________

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

Signature of physician: ____

Date: __________________________