ST. MARY'S UNIVERSITY

Medical Documentation: Student with Functional Limitations due to Medical Condition

Name of Student: _____ Birthdate: _____ Date: _____

Dear Medical Professional:

The student whose name appears above has applied for disability services and accommodations at St. Mary's University. In order for the office to establish whether this student has a disability and to determine his/her eligibility for services, we will need your clinical assessment/diagnosis of this student. A disability as a physical impairment that substantially limits one or more major life activities such as those delineated below.

1. Is the student currently under your care? If yes, for how long?

2. What is the diagnosis/impairment/condition? (Please describe and use ICD 10/DSM 5 diagnostic codes):

3. Date diagnosis was made: 4. When did you last see the patient/student?

5. Major Life Activities Assessment: Please attach any supporting information (neurological or psychological testing reports) Please indicate by number below as this relates to the diagnosis you are treating:

Life Activity (1-Negligible) (2-Moderate) (3-Substantial) (You may include additional information after item)

Speaking: _____ Walking:_____ Breathing:_____ Standing:_____ Reaching:_____ Lifting:_____ Sitting:_____

Hearing:_____ Seeing:_____ Performing Manual Tasks:_____ Writing:_____ Sleeping:_____ Concentrating:_____

Memorizing:_____ Reading:_____

Caring for oneself (specify):

Other (Please include any social aspects specifically):

6. What are the specific functional limitations resulting from the impairment's impact on the major life activities in a learning environment identified above (e.g. unable to keyboard more than 10 minutes out of 60 minutes) and recommendations for this individual:

7. Are the functional limitations permanent? If not, anticipate date of resolution? Prognosis?

8. If student is currently undergoing treatment (e.g. chemo therapy, Rx, etc.) please describe the treatment and how this treatment may affect the student in a post-secondary environment.

_____ _____

Medical Professional's Name (printed) License No. Signature of Medical Professional Date

_____ _____

Address Telephone Fax