Temporary Disability Documentation Form

This form must be completed and returned by a licensed treating professional. Send completed forms to the Office of Accessibility Services via email at accessibility@clarkstate.edu or via fax 937-328-7969. Direct questions to the office 937-328-6019 or accessibility@clarkstate.edu.

This form may be used to document temporary disabilities or medical conditions, including pregnancy, childbirth, termination of pregnancy, lactation, and related recovery needs, in accordance with Title IX and the ADA.

Name: _____ **Student Date of Birth (DD/MM/YYYY):** _____

Semester: _____ **Requested Accommodation Start Date:** _____

I, _____ (health care provider name) recommend the following for the above student's related medical needs.

Temporary medical condition or disability impacts on academic participation:

☐ Student can fully participate in coursework and attend in-person classes.

☐ Student cannot participate in coursework or attend classes for the remainder of the semester.

☐ Student can engage in coursework (e.g., online, asynchronous,) after a period of recovery.

Anticipated start date: _____

Restrictions listed below: ☐ Yes ☐ No

Date restrictions are lifted: _____

☐ Student can attend in-person classes after a period of recovery.

Anticipated return date: _____

Restrictions listed below: ☐ Yes ☐ No

Date restrictions are lifted: _____

☐ Other: _____

Return date: _____

Temporary medical condition or disability impacts for clinical environments:
Clinical participation determinations are made with consideration of patient safety, student safety, and program requirements.

☐ The student is permitted to return to clinical

Return date: _____

Restrictions indicated below: ☐ Yes ☐ No

Date restrictions are lifted: _____

☐ At this time, the student is not permitted to return to clinical as a safety precaution.

Physical limitations/restrictions after returning to coursework/in-person classes (clinical included):
Please include anticipated duration or re-evaluation date for each limitation. The functional impacts may reflect any temporary medical condition, including pregnancy-related needs. Diagnosis is not required.

☐ Walking/standing

Duration and details:

☐ Sitting

Duration and details:

☐ Lifting/carrying

Duration and details:

☐ Driving

Duration and details:

☐ Breaks during class

Duration and details:

☐ Other

Duration and details:

Please provide additional information relevant to supporting the student:

Name: _____

Name of Practice/Organization: _____

Phone number: _____ **Email:** _____

Signature: _____ **Date:** _____

NOTE: If there are changes to the student's temporary disabilities, an updated form should be completed and submitted to Office of Accessibility Services.