Temporary Disability Documentation Form

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

Semester: _____ Requested Accommodation Start Date: _____

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

Short-term disability impacts:

☐ Student has no restrictions and can return to coursework and in-person classes immediately.

☐ Student will be unable to participate in coursework and cannot attend classes for the remainder of the semester.

☐ Student will be able to participate in coursework after a period of recovery following the medical event.

Return date: _____

☐ Student will be able to attend in-person classes after a period of recovery following the medical event.

Return date: _____

☐ Other: _____

Return date: _____

Physical limitations/restrictions after returning to coursework/in-person classes (clinical included):

☐ 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.