Accommodation Medical Certification 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 at 937-328-7969. Direct questions to the office at 937-328-6019 or accessibility@clarkstate.edu.

SECTION 1: TO BE COMPLETED BY STUDENT

Name: _____ **Student ID#:** _____

Major/Program: _____

SECTION 2: TO BE COMPLETE BY LICENSED HEALTHCARE PROVIDER

FUNCTIONAL IMPACT INFORMATION

This section documents functional limitations that may affect the student's access to academic programs or campus activities. Please do not recommend specific academic accommodations as the Office of Accessibility Services will assume responsibility for determination of accommodations based on documented functional limitations and environmental barriers.

Diagnosis and Relevant Medical Information

Please provide the diagnosis, key symptoms and treatment relevant to the student's functional abilities.

Impact on Major Life Activities

Identify major life activities affected (ie: concentrating, learning, communicating, seeing, walking, lifting, regulating emotions, major bodily functions). For each, describe:

- ***Severity:*** *Mild / Moderate / Severe*
- ***Frequency:*** *Intermittent / Episodic / Constant*
- ***Functional Impact:*** *How the major life activity is impacted across different environments (consider learning, social, employment and/or stressful environments etc.).*

Duration and Variability

Please check the applicable length.

☐ **Chronic / Long-Term** ☐ **Fluctuating / Episodic** ☐ **Temporary (estimated end date):** _____

☐ **Unknown / Variable:** Describe variability if relevant.

Additional Relevant Information

Provide any additional clinical information that helps explain the student's functional presentation. Please do not recommend specific academic accommodations as the Office of Accessibility Services will assume responsibility for determination of accommodations based on documented functional limitations and environmental barriers.

SECTION 3: HEALTHCARE PROVIDER INFORMATION

Name: _____ **Practice:** _____

Phone: _____ **Email:** _____ **Fax:** _____

Signature: _____ **Date:** _____