

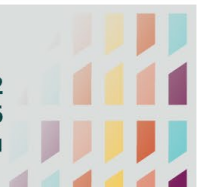
CERTIFICATION OF DISABILITY

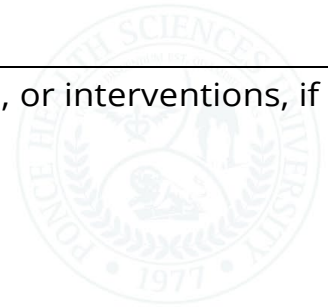
Reasonable Accommodation



Medical Disability Evaluation

Name of student:	Date of birth:
Diagnosis / disability (ICD Code):	Date of diagnosis (onset):
Prognosis:	Coexistent condition, if apply:
Impact on Academic and Daily Functioning	
Approximately, how long do you understand the student will need a reasonable accommodation?	
Please describe how the student's condition affects their academic and daily functioning:	
Please describe any limitations resulting from the condition that interfere with the student's ability to perform their academic tasks, but that can be managed with reasonable accommodations.	





Please list any ongoing treatment, including therapy, medications, or interventions, if apply:

Please provide a summary of the assessment procedures used to diagnose the condition, if is relevant:

How long have you been treating this student?

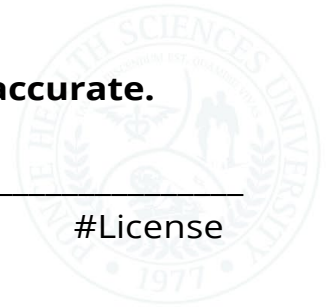
Recommended Accommodations

Recommend specific accommodation, including assistive devices, for both test-taking and the academic setting (classroom). These accommodations must be targeted to alleviate the impact of specific disability on access to education or fair testing.

Please specify why these accommodations are necessary and how they will alleviate the impact of the identified functional limitations in academic settings or exams.

Accommodation recommended	Justification for need





I hereby certify that the information provided is true and accurate.

Name of specialist:

Specialty

#License

Address

Telephone

Signature

Date



Revised 01/2025

