Certification of Physical Disability and Functional Limitations

Due to Medical Condition

Student Accessibility
College Center, Room C-019
800 Main Street, Pewaukee, WI 53072
Voice/Relay: 262.691.5318 | Fax: 262.691.5089
SAO@wctc.edu

The student named below has applied for services from the Student Accessibility Office at WCTC. In order to provide reasonable and appropriate services for students with disabilities, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist the Student Accessibility Staff in providing sufficient information so that eligibility for services can be determined. The information you provide will not become part of the student's educational records and will be kept in the student's confidential file. In addition to the requested information, please attached any additional information; for example, your report and any test results. Thank you for your assistance.

Please print legibly

1. Student's name _____ Date _____

2. Date of diagnosis _____ Student's DOB_____

3. Identified limitations _____

4. Is this student currently under your care?_____

5. When did you last see this student? _____

6. Major life activities assessed _____

Please check any of the major life activities listed on this page that are affected because of the limitations. *Please indicate level of limitation.*

Life Activity	*1 – Negligible*	*2 – Moderate*	*3 – Substantial*
Talking	☐	☐	☐
Hearing	☐	☐	☐
Breathing	☐	☐	☐
Standing	☐	☐	☐
Working	☐	☐	☐
Reaching	☐	☐	☐
Lifting	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Seeing	☐	☐	☐
Writing	☐	☐	☐
Performing Manual Tasks	☐	☐	☐
Sleeping	☐	☐	☐
Learning	☐	☐	☐
Reading	☐	☐	☐
Thinking	☐	☐	☐
Concentrating	☐	☐	☐
Memorizing	☐	☐	☐
Interacting with Others	☐	☐	☐
Caring for Oneself	☐	☐	☐
Other: _____	☐	☐	☐
_____	☐	☐	☐

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WAUKESHA COUNTY TECHNICAL COLLEGE

Certification of Physical Disability and Functional Limitations

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7. What are the specific functional limitations resulting from the impairment's impact on the major life activities identified above (i.e., unable to lift more than 10 lbs.; unable to keyboard more than 10 minutes out of 60 minutes)?

8. Are these limitations permanent? If not, what is the anticipated date of resolution?

9. Medications, effects, and possible side-effects:

10. If student is currently undergoing treatment, please describe the treatment and how treatment may affect the student in a post-secondary setting.

11. Please indicate which accommodations, if any, may be beneficial to this student.

- ☐ Low distraction test environment
- ☐ Extended test time
- ☐ Note taking support
- ☐ Text-to-speech for textbooks
- ☐ Closed caption media
- ☐ Interpreting
- ☐ Reduced credit load
- ☐ Other _____

12. Is there anything else you would like us to know about this student?

Signature of professional _____ Date _____

Medical professional's name (printed) and title _____

License number _____

Address _____ City _____

State _____ Zip _____

Telephone number _____ Fax number _____

WAUKESHA COUNTY TECHNICAL COLLEGE

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