Student Accessibility
800 Main Street, Room C-021
Pewaukee, WI 53072
262.691.5318 (Phone)
262.691.5089 (Fax)

Certification of Physical Disability and Functional Limitations Due to Medical Condition

The student named below has applied for services from the Student Accessibility area 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 clinicians 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.

1. Student's name ________________________________ Date ____________________
2. Date of diagnosis ________________________________ Student's DOB ____________________
3. Identified impairment ________________________________
4. Is the patient/student currently under your care? ________________________________
5. When did you last see the patient/student? ________________________________
6. Major life activities assessed ________________________________

Please check any of the major life activities listed on this page that are affected because of the impairment. *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: ____________________	☐	☐	☐
____________________	☐	☐	☐

WAUKESHA
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(continued)

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.
    - ☐ Distraction free test environment
    - ☐ Extended test time
    - ☐ Note taking support
    - ☐ Tape recorded textbooks
    - ☐ 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 ____________________

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