SOUTHERN STATE
COMMUNITY COLLEGE

VERIFICATION OF A MEDICAL DISABILITY

The Disability Services Office provides services to students with medical disabilities. In order to determine eligibility for services and appropriate accommodations, this office requires current and comprehensive documentation of the medical condition from the diagnosing physician or physician currently treating the student.

Please answer the following questions pertaining to: _____

Date: _____ Client's DOB: _____

1. What is the diagnosis, date of diagnosis, and last contact with the student?

2. Is the student/patient currently under your care?

3. Please describe the progression of this condition if applicable.

4. List current medication(s), impact, and adverse side effects.

5. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically.

6. Major Life Activities Assessment:
   Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

Life Activity	1- Negligible	2-Moderate	3-Substantial
Talking			
Hearing			
Breathing			
Standing			
Caring for Oneself			
Reaching			
Lifting			
Sitting			
Walking			
Seeing			
Performing Manual Tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Memorizing			
Interacting with Others			
Writing or note taking:			
Other:			
Other:			

7. Describe the medical condition may result in the functional limitations in an academic setting (ie. Problems sitting for long periods of time, unable to type, write or note take, to keep up with class or for more than ten minutes, or unable to walk more than 50 feet without fatigue)?

8. What is the expected duration of this disability?

9. What recommendations do you have regarding accommodations, i.e., extra time for exams, note taker, disability parking, and adaptive transportation. Please describe your rationale for the accommodations you have recommended.

10. Are there other associated disabilities? If so, what are they? Please describe these conditions and any functional limitations.

11. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

Signature: _____

Print Name and Title: _____

Address: _____

_____

Telephone: _____

Return this information to the address below to the attention of:
Ann Ernst (aernst@sscc.edu)
Accessibility and Learning Services.
1.800.628.7722 extension 2535