BROWARD COLLEGE | ACCESSIBILITY RESOURCES

A. Hugh Adams Central Campus
3501 S.W. Davie Road, Davie, FL 33314
Phone 954-201-6527 | Fax 954-201-6446

PHYSICAL, SENSORY, AND OTHER MEDICAL DISORDERS VERIFICATION FORM

Student Name and ID#: _____

Date of Birth: _____ Phone: _____ BC email: _____

The following information is to be completed by a qualified health professional and either returned directly to Accessibility Resources or the student. This information will be used to assist Broward College in determining appropriate accommodations.

Specific Diagnosis (one per form)			
Date of Diagnosis			
How long has the student been your patient?			
Prognosis (check one)	___ Permanent	___ Temporary	**How long?**
Severity (check one)	___ Mild	___ Moderate	___ Severe
Fine Motor Skills (check one)	___ Needs assistance with writing	___ Can write but needs additional time	___ No writing assistance needed

Is there an indication of problems with pain _____ or fatigue _____?

Current medications

_____
_____
_____
_____

Side effects

_____
_____
_____
_____

How does this student's disability affect them in an educational setting?

_____
_____

If this is a **visual** or **hearing** disability, please respond to the following:

Visual Acuity/Low Vision: Please attach test results.

Hearing: ASL interpreter required? ___Yes ___No Please attach an audiogram and any additional information.

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Physical Ability Assessment

Student Name and ID#: _____

Please mark all areas that apply to this student's physical disability limitations.

Lifting Upper Body	**Walking**	**Standing**	**Running**
No limitations:	No limitations:	No limitations:	No limitations:
Maximum # lbs. :	Maximum distance:	Maximum time:	Maximum time:
Lifting Lower Body	**Carrying**	**Sitting**	**Pushing**
No limitations:	No limitations:	No limitations:	No limitations:
Maximum # lbs. :	Maximum # lbs. :	Maximum time:	Maximum # lbs. :
Pulling	**Grasping**	**Kneeling**	**Reaching**
No limitations:	No limitations:	No limitations:	No limitations:
Maximum # lbs. :	Limitation:	Limitation:	Limitation:
Crouching	**Climbing**		
No limitations:	No limitations:		
Limitation:	Limitation:		

_____ _____
Physician's Signature Date

_____
Print Name, Title, License Number

_____
Address and Phone Number