

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)	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary	How long?
Severity (check one)	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Fine Motor Skills (check one)	<input type="checkbox"/> Needs assistance with writing	<input type="checkbox"/> Can write but needs additional time	<input type="checkbox"/> 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.

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