

To be completed by a licensed/certified professional (continued)

Mobility Limitation (continued)

a. What kind of mobility restrictions does the student experience?

Visual Impairment

Left

Right

7. Diagnoses:

a. Acuity

b. Field

Recommended accommodations:

Hearing Impairment: Please include a current audiological report.

Left

Right

8. Diagnoses:

a. DB Loss

b. Hearing Aids

9. Ability to Sign?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expert	Good	Fair	Poor	None	I don't know

Recommended accommodations:

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10. How does the student's disability substantially limit his/her ability to function in an academic environment (i.e. mobility, attendance, classroom activities, test taking, etc.)?

11. Suggested accommodations:

12. Additional comments:

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more major life activities of such individual" as defined by the Americans with Disabilities Act.

In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge

Name of professional please print

Signature of professional

Date

Professional Credential _____

License/Certification #

Street Address

City

State

Zip

Please return this form as soon as possible so this student may receive accommodations.

Please include the necessary verifying documents from your files.