PHYSICAL/MEDICAL/SENSORY IMPAIRMENT
DISABILITY DOCUMENTATION FORM

This form must be signed by a medical/clinical professional with an accompanying note on letterhead and returned to Student Disabilities Services.

Date: _____ Name of Student: _____

1. What is the name of the diagnosis/diagnoses?

2. How long has student had this condition?

3. What is the severity of this condition?

4. Provide duration or recovery period expected.

5. What tests, if any, were relied upon in reaching the diagnosis?

6. Does the condition significantly limit a major life activity of this student?
   [ ] Yes [ ] No

   a) If so, explain how any limitation on a major life activity is ameliorated or eliminated by any treatment or medication being given to this student.

7. Is there a current treatment plan? [ ] Yes [ ] No

   a) If yes, please describe:

University of Pennsylvania,
Weingarten Learning Resources Center, Student Disabilities Services
3702 Spruce Street (Stouffer Commons), Suite 300
215.573.9235 (v) 215.746.6326 (fax)
http://www.vpul.upenn.edu/lrc/sds

b) List current medication(s), dosage, frequency and adverse side effects, if any:

8. Explain other information that may be relevant:

9. If the diagnosis prevents the student from performing any of the requirements of a course or academic program, please:

   a) specify accommodation(s) to assist the student in performing these functions:

   b) rationale for recommended accommodations (based on functional limitations):

CERTIFYING MEDICAL PROFESSIONAL

Name:_____
(Please print)

Signature:_____

License:_____

Address:_____

_____

Telephone:_____ Fax:_____

Email:_____

This information will be reviewed and accommodation decisions made in accordance with the policies of the University of Pennsylvania. Please return this form to the address below or fax to Student Disabilities Services. For more information or discussion call (215) 573-9235 (Voice) or (215) 746-6320 (TDD) or (215) 746-6326 (FAX).

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