



**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 Disability 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:

- 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 student or Disability Services at (215) 746-6326 (fax).