CARDINAL STRITCH UNIVERSITY

Physical, Sensory, and Health Related Documentation

(To be completed by a qualified medical doctor or specialist)
~Please type or print neatly / use a separate sheet if needed~

Student Name (First, MI, Last) _____

Diagnosis: _____

When was diagnosis made? _____ Last date of contact with student: _____

Is condition: ____Temporary _____Permanent Level of severity: _____ Mild _____ Moderate ____ Severe

If sensory, please provide specific explanation of disability (such as visual acuity if low/blind; hearing levels if hearing impaired/deaf)_____

_____

If medical or health, provide a description of your patient's medical condition or symptoms:

_____

_____

Provide a description of the student's functional limitations as a result of this condition, and how they might impact this student's academic activities (such as reading, writing, note-taking, concentration, studying, interactions with others, instructors and students, etc.) _____

_____

_____

Suggested accommodations: _____

_____

_____

Professional's Signature:_____ License #:_____

Print or type name and title: _____

Address: _____

Phone: _____ Date: _____

Direct questions to:

Michael Schade, Accessibility Services Coordinator
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