PACIFIC UNIVERSITY
OFFICE OF LEARNING SUPPORT SERVICES

Documentation of Medical Disability

RELEASE:

I, _____, hereby authorize the release of the following information to Learning Support Services at Pacific University for the purpose of determining my eligibility for academic accommodation.

Student's Signature: _____ Date: _____

TO BE COMPLETED BY QUALIFIED HEALTH PROFESSIONAL

The student named above is requesting disability-related accommodations from Pacific University. The student has authorized a release of medical information to the Director, Learning Support Services. This information will be held in strict confidence and will be used solely to determine the student's eligibility for services as mandated under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, and in determining the most appropriate accommodations based on the student's current level of functioning. It will not become part of the student's permanent academic file. Please help us to make the best possible decision by carefully filling out this form and attaching any other pertinent records. Thank you.

Diagnosis: _____

Please describe the diagnosis in *layman's terms*: _____

_____

_____

Date of diagnosis/onset: _____

Prognosis: _____ Permanent _____ Temporary

If temporary, expected duration: _____

Does the disability limit/impact physical activities associated with University attendance?

_____ No _____ Yes

If yes, indicate what type of activities and to what extent:

Hand/arm mobility: _____

Sitting: _____

Walking: _____

Climbing one flight of stairs: _____

Does this disability affect academic pursuits (e.g., cognition, attention, vision, hearing)?

_____ No _____ Yes If yes, explain to what extent: _____

_____

_____

(continued on other side)

What treatment, if any, is the student currently receiving? If medication has been prescribed, please indicate name and dosage. Are there side effects which may interfere with the student's functioning? _____

_____

_____

_____

Date of last visit: _____

Frequency of monitoring: _____

The University provides academic services and accommodations to ensure equal access to its programs by persons with disabilities. What recommendations do you have that would assist the student in the academic setting: _____

_____

_____

_____

Additional comments: _____

_____

_____

_____

HEALTH PROFESSIONAL:

Name: _____

Signature: _____ Date: _____

Position: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Please return to:

Kim Garrett, MRC
Interim Director, Learning Support Services
Pacific University
2043 College Way, UC Box A111
Forest Grove, Oregon 97116