LAWRENCE MEMORIAL/REGIS COLLEGE

Documentation for Disability/Medical Condition
MEDICAL PROVIDER FORM

I. Student

Name: Last ________________________First________________________ Date of Birth _______________

Home Phone _______________________ Cell Phone____________________ E-mail _____________________

Address____

II. Certifying Professional

Name____

Professional Title __________________________________Highest Degree_____________________________

Phone____ E-mail______________________________________

Address____

License/certification, number, and state: ____

III. Diagnosis(es): ____ DSM # ________________

a. Date of first diagnosis: ____________ Date of last contact regarding diagnosis: __________________

b. Please list relevant diagnosis(es) Please attach additional page if necessary

Diagnosis(es)	Does this condition substantially limit a major life activity (yes, no, when active)?	Would you rate the disability/condition as being mild, moderate or severe?	Is the condition stable, variable, or progressive?

c. Please check the "major life activity/ies" the disability/condition impedes:

_____ caring for oneself _____ performing manual tasks _____ seeing
_____ hearing _____ eating _____ sleeping
_____ walking _____ standing _____ lifting
_____ bending _____ speaking _____ breathing
_____ learning _____ reading _____ concentrating
_____ thinking _____ communicating _____ working

Please complete page 2

Please return to: Colleen M. Walsh, MBA, Director, Student and Alumni Services
170 Governors Ave., Medford, MA 02155 FAX: 781 306-6142

d. How will the limitations of the disability/condition affect the student's ability to function? What conditions will cause the disability manifest?

e. Please describe the possible impact on academic performance and social development *if this student's requests are not met:*

f. Additional information or suggested accommodations based on findings:

Print Name: ____

Signature: ____ Date: ________________

2/21/13jwj

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