Certification of Medical, Educational or Psychological Disability

Application for services: Please have your medical professional fill out this form concerning your disability. Once the diagnosing medical professional has completed the form, you should submit the form to the Office of Disability Services Coordinator, along with any other written verification of a disability that you wish to be considered.

Student's Name: ___________________________ DOB: _______________________

Today's Date: ___________________________

Date of Diagnosis: _______________________

Date Student was Last Seen: ______________

Please type or print clearly.

1. What is the medical/psychiatric diagnosis for the above individual?

2. What major life activity is affected by the diagnosis?

3. What is the level of limitation?

4. How might the student’s disability affect his/her academic performance?

5. What medication is the student currently taking?

6. Does the condition persist with medication?
7. How might side-effects, if any, affect the student's academic performance?

8. Please describe the expected progression or stability of the impact of the student’s disability.

9. Might the student be considered harmful to self or others around him or her? Please Explain.

10. Is there anything else you think we should know about the student's medical/psychological disability?

CERTIFIED PROFESSIONAL

Print Name: ____________________________________________________________

Signature: ________________________________________________

License Number: ________________________________________________

Address: _________________________________________________________

Telephone: _______________________ Fax: _________________________________

Please return completed form to:

Sherry Kinzler
Office of Disability Services
Kankakee, IL 60901
815-802-8632 office
815-802-8101 fax
skinzler@kcc.edu