

**CONFIDENTIAL**

**PHYSICIAN CERTIFICATION**

**For Students with Mobility and Other Physical Disabilities**

This information is used to provide appropriate support services based on the functional limitations in an academic setting which are related to medically diagnosed disabilities.

**Section I: To be completed by student:**

Name: _____	Sac ID#: _____	DOB: _____
I authorize _____ (my physician/medical care practitioner and/or Medical Records Dept.) to release the requested medical information and additional clarification relevant to the impact of my disability on my education.		
Signature _____	Date _____	

**Section II: To be completed by the physician (not student):**

Date of last office visit: _____				
<u>Diagnosis</u>	<u>Date of Diagnosis</u>	<u>Permanent</u>	<u>Temporary</u>	<u>Recovery Date</u>
_____	_____	_____ (or)	_____	_____
_____	_____	_____ (or)	_____	_____
_____	_____	_____ (or)	_____	_____
_____	_____	_____ (or)	_____	_____

<u>Medications</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Assistive devices used by student:** \_\_ Yes \_\_ No Describe: \_\_\_\_\_  
**REVERSE SIDE --->**

**Please indicate all functional limitations and symptoms which may impact mobility, classroom participation or test performance, scheduling of classes, etc:**

**I. Maximum time/distance without a break:**

Walking: \_\_\_\_\_ yards (or) \_\_\_\_\_ minutes    Standing: \_\_\_\_\_ minutes (or) \_\_\_\_\_ hours  
Sitting: \_\_\_\_\_ minutes (or) \_\_\_\_\_ hours    Climbing stairs: \_\_\_\_\_ flights (or) \_\_\_\_\_ none

**II. Use of hands: Restrictions?**

Fine manipulation/grasping: \_\_\_Right    \_\_\_Left  
Pushing/pulling/or lifting    \_\_\_Right    \_\_\_Left  
Handwriting    \_\_\_Right    \_\_\_Left    Which hand is dominant? \_\_\_Rt \_\_\_Left  
Keyboarding    \_\_\_Right    \_\_\_Left    Duration: \_\_\_\_\_ minutes

**III. Sensitivity to:** Heat? Cold? Light? Sun? Dust/fumes? Other? (circle any that apply)  
\_\_\_\_\_Mild    \_\_\_\_\_Moderate    \_\_\_\_\_Severe

**IV. Medical condition requires:** Frequent or unpredictable restroom breaks: \_\_\_Yes    \_\_\_No

Meal/snack breaks \_\_\_Yes \_\_\_No    Water/drink in classroom \_\_\_Yes \_\_\_No

**V. Sleep disorder:** \_\_\_Yes \_\_\_No    **Speech disorder:** \_\_\_Yes \_\_\_No  
\_\_\_Mild \_\_\_Moderate \_\_\_Severe    \_\_\_Mild \_\_\_Moderate \_\_\_Severe

**VI. Seizures:** Frequency, type, typical time of day? \_\_\_\_\_

Typical postictal symptoms & duration: \_\_\_\_\_

Any known triggers? \_\_\_\_\_

**VII. Chronic pain:** \_\_\_Yes \_\_\_No    If yes: \_\_\_Mild \_\_\_Moderate \_\_\_Severe

**Chronic fatigue:** \_\_\_Yes \_\_\_No    If yes: \_\_\_Mild \_\_\_Moderate \_\_\_Severe

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Certified License Number

\_\_\_\_\_  
Address    # Street    City    State    (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_  
PH #: Area Code / Number

Services to Students with Disabilities at California State University-Sacramento reserves the right to make the final determination concerning the eligibility and continuation of services. Additional medical documentation may be requested if the information provided does not adequately address the student's functional limitations in an academic setting.