

Documented Disability Form

A medical/clinical professional must sign this form, include an official office stamp or an accompanying note on letterhead, and return to the Office of Accessibility Services.

Student Information

Last Name _____ First Name _____

ID# _____ Date of Birth _____ Gender Female Male

Student Release of Medical Information

I authorize my physician or any other professional clinician who may share in my care to release to the designated representative of Wiley College all information that shall be required concerning my diagnosis to determine eligibility for support services under the Services for Students with Disabilities Program.

Student Signature

Date

TO BE COMPLETED BY PHYSICIAN OR OTHER PROFESSIONAL CLINICIAN

1. What is the diagnosis/impairment?
2. When was the diagnosis originally made?
3. What tests, if any, were relied upon in reaching the diagnosis/es identified in question 1?
4. Does the condition identified significantly limit a major life activity of the student? No Yes
If yes, please indicate how.
5. Please describe symptoms associated with condition.

6. Describe how the condition may affect this student both academically and/or physically?

7. Please specify accommodation(s) which may assist the student in his/her postsecondary educational program.

- a) _____
- b) _____
- c) _____
- d) _____
- e) _____

8. Are there any special housing needs required? No Yes (provide details below)
Are there any special dietary restrictions or needs? No Yes (provide details below)

All medical housing residents are subject to random health and safety inspections.

Please print or type the information below and include official office stamp in the blank space below:

Name/Title _____

Address _____

Zip _____

Phone _____

Fax _____

Signature _____ Date _____
Medical/Clinical Professional

License # _____ State _____

STAMP HERE

For more information or to discuss, contact the Accessibility Coordinator, at ahart@wileyc.edu, 903-923-1684 (office).