CHADRON STATE COLLEGE
CLINICAL DOCUMENTATION FORM

Please submit to:
Disability Services, Chadron State College
1000 Main Street, Chadron, NE 69337
Fax: 308-432-6409 Email

THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE STUDENT

Student Name:_____
First Middle Last

Student's Consent for Release of Information: I, _____(student),

give_____(medical provider) permission to provide the information requested below to the Disability Services office at Chadron State College. I give permission for my provider to release any additional information required by the Disability Services office which might be needed to determine eligibility for accommodation requested. I understand that this information will become a part of my record at the Disability Services Office.

Student Signature: _____Date:_____

THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE MEDICAL PROVIDER

Dear Doctor/Health Professional: Please answer each question in the space provided.

A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits a major life activity".

Examples of major life activities are: walking, speaking, breathing, hearing, seeing, thinking, sitting, sleeping, working, learning, interacting with others, concentrating, performing manual tasks, or caring for oneself.

1. **Based on this definition, does the individual have a physical or mental impairment: Yes No**

If the answer to question 1 is yes, please answer the following questions:

a. **What specifically is the impairment?**
_____
_____

b. **Which major life activities are limited by the impairment?**
_____
_____

c. **How many days/months did the impairment limit major life activities during the past year?**
_____
_____

d. **What is the expected duration of the impairment?**
_____
_____

e. **What are the expected permanent or long term effects of the impairment?** _____
_____
_____

f. **Does the student take medication(s)? Yes No**

i. **If yes, list medication(s)**
_____
_____

ii. **Does the medication(s) relieve the symptoms?**
_____
_____

2. **Specifically state what accommodations you recommend and what benefits these accommodations will have with regard to the individual's impairment.**

_____
_____
_____
_____

3. **Please provide any additional information you feel would be helpful.**

_____
_____
_____

MEDICAL PROVIDER

Medical Provider's Printed Name: _____

Signature: _____**Date:**_____

Address: _____

Phone Number: _____