Office of Student Disability Services
Eastern Illinois University
600 Lincoln Avenue
Charleston IL 61920-3099
217-581-6583 (Voice/TTY)
217-581-7208 (Fax)

PHYSICIAN'S STATEMENT
TO DETERMINE ELIGIBILITY FOR A FUNCTIONAL OR PHYSICAL IMPAIRMENT

Please return the completed form to the Director of Student of Disability Services at the above address.

Student Name: _____ Today's Date: _____

The above named individual is a student at Eastern Illinois University. S/he is requesting support services/accommodations for a physical or functional disability. The University is committed to providing reasonable accommodations and academic support to all students who have a disabling condition as defined by federal legislation (the 1973 Rehabilitation Act [Section 504] and the 1990 Americans with Disabilities Act). University policy requires that students requesting such assistance provide verification of disability from the student's attending physician. The documentation must be submitted to the Office of Student Disability Services in a reasonable amount of time for the University to provide the necessary accommodations.

Under the Americans with Disabilities Act, an individual with a disability is any person who:

1. Has a physical or mental impairment which substantially limits one or more major life activities;
2. Has a record of such impairment; or,
3. Is regarded as having such an impairment.

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Please provide the following information:

Diagnosis: _____

Date of initial diagnosis: _____ Date of last visit: _____

How often do you meet with this individual? _____

Frequency of episodes: _____

Severity of episodes: _____

Please complete the reverse side of this form.

Dates of hospitalizations and emergency room visits for this condition: _____
_____

What situations are likely to immediately trigger an episode of this condition (e.g. low sugar levels, smoke, etc.)? _____

What repetitive situations are likely to trigger an episode of this condition? _____
_____

Current treatment for this condition: _____
_____
_____

List any medication(s) prescribed and side effects experienced: _____
_____
_____

Please check all major life activities that are affected by this condition:

☐ breathing ☐ walking ☐ hearing ☐ seeing ☐ working ☐ learning
☐ performing manual tasks ☐ caring for oneself ☐ no major life activities are affected

What are the functional limitations of the disability? _____
_____

List accommodations you would recommend relative to the disability: _____
_____

Please list pertinent testing that helps to confirm diagnosis:

Test	Date	Results

Please attach medical information that is needed to substantiate a disability and the need for accommodations (i.e., current medical records, additional copies of test results etc.)

Thank you for your help in providing this information so that we may begin providing services as soon as possible. Please return this form to the address shown on the letterhead.

Physician's signature: _____

Printed name and title: _____

Office address: _____

Office telephone: _____ Date: _____