CARROLL UNIVERSITY
Walter Young Center

ACADEMIC ACCOMMODATIONS
Physical, Sensory, and Health Related Documentation

(To be completed by a qualified medical doctor or specialist)
Please type or print neatly/ use a separate sheet if needed

Student Name (First, MI, Last) ____

What is the diagnosis? ____

Level of severity (if applicable) ____Mild _____Moderate ____Severe

When was the diagnosis made? ____________________Last date of contact with student: _____________________

Is this condition: ______Temporary _____Permanent

If physical or sensory, please provide specific explanation of disability (such as visual acuity if low/blind; hearing levels if hearing impaired/deaf) ____

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If medical or health, provide a description of your patient's medical condition or symptoms:

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Provide a description of the student's functional limitations as a result of this condition, <u>and</u> how they might impact this student's academic activities (such as reading, writing, note-taking, concentration, studying, interactions with others, instructors and students, etc.) ____

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Suggested accommodations: ____

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Professional's Signature:____ License #:__________________________

Print or type name and title: ____

Address: ____

Phone: _______________________ Date: _____________________________

Direct questions to, or simply submit this form via fax, e-mail or mail to:

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