TEXAS A&M UNIVERSITY
CORPUS CHRISTI

Disability Services
6300 Ocean Drive, Unit 5717
Corpus Christi, Texas 78412-5717
Office: 361-825-5816 • Fax: 361-825-2536

MEDICAL DISABILITY VERIFICATION FORM

To be used for Mobility Limitations and/or Perceptual Limitations such as Visual, Hearing and other Health Impairments or Chronic Illness

SECTION I - To be completed by the student.

Name ____ Student ID#______________________

Address ____

Phone ______________________________ Date of Birth ______________________

Physician or Appropriate Professional ____

Phone _____________________ FAX ___________________

Address ____

____

I authorize the release of the information requested on this Disability Verification Form to the Disability Services Office at Texas A&M University-Corpus Christi.

____ ______________________________

Student Signature Date

SECTIONS II & III - To be completed by physician or other certifying professional.

A. COMPLETE FOR YOUR PATIENT/CLIENT WITH *MOBILITY LIMITATIONS*

What restrictions does this individual have regarding the length of time engaged in:

Sitting __________________ Writing __________________ Walking __________________

Functional limitations which may require alterations to traditional classroom seating, lab/work station, library research, etc.:

____

____

B. COMPLETE FOR YOUR PATIENT/CLIENT WITH *PERCEPTUAL LIMITATIONS*

Visual Impairment: Visual Acuity Left ___________ Right ___________

Field Left ___________ Right ___________

Comments

____

Hearing Impairment: dB Loss (Please use current audiogram) Left ___________ Right ________

Comments ____

*PLEASE SEE BACK OF PAGE FOR **YOUR SIGNATURE** AND ADDITIONAL DISABILITY CATEGORIES.*

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SECTION III. Complete for All Patients/Clients

A. Diagnosis ______________________________ Prognosis ____________________

This disability is: (check one) Permanent [ ] Temporary [ ]
If temporary, disabling condition is expected to last:

____________________ weeks days months (circle one)

B. Briefly describe the functional limitations of the disability, effect of medications, etc., on ability to meet class requirements.

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____

C. Name of certifying professional (please print) ______________________________

Title ______________________________ Certification or license # ____________________

Address ____ Phone ____________
(Street) (City) (State) (Zip)

I verify that the above information is complete and accurate to the best of my knowledge.

______________________________________ ______________________________

Signature of physician or appropriate professional Date

Thank you for your assistance.

Revised 04/10/09