Documentation Form for Temporary Impairments
(as the result of injury, surgery, etc.)

Student Name_____________________________________________________   Banner ID _____________________

In order to determine eligibility for reasonable accommodations and/or determine appropriate resources relevant to a temporary impairment, the following materials are generally needed:

1. **Temporary Impairment Disclosure Form:** (to be completed by individual requesting accommodations) and

2. This form, prepared by a qualified professional

THE FOLLOWING IS TO BE COMPLETED BY A QUALIFIED PROFESSIONAL/PHYSICIAN

Note: This form may only be completed for a temporary impairment (such as injury, surgery, etc.), and is typically not sufficient for determining accommodations and resources long term.

1. Diagnosis/Impairment: ____________________________________________________________

2. Date of impairment: ________________________________________________________________

3. Date of most recent office visit: _____________________________________________________

4. Describe the impact and functional limitations relevant to life activities, including academics:

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

5. Are there treatments, medications, etc. which will adversely impact the student’s baseline function, if so, how?

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

6. Expected duration of temporary impairment/condition: _________________________________

7. Anticipated date of full recovery: ____________________________________________________

8. Recommendations (should be directly linked to the impact or functional limitations associated with the impairment):

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

12. Organization: ___________________________________________________________________

13. Professionals' Signature & License #: ________________________________________________

14. Please attach a copy of your business card and submit this completed form to the Office of Disability Resources.