

To Whom It May Concern:

A patient/client of yours has requested disability-related services from the Office for Disability Services at Lincoln College - Normal. Legal protection and eligibility for such services is based on an individual providing sufficient information to conclude that he or she has an impairment that **substantially limits** one or more major life activities. As this student's treating specialist, you are asked to provide the following information to allow the university to consider this student's service request(s).

Please complete the following:

<b>1.</b>	<b>Patient/Client Name:</b>
<b>2.</b>	<b>The Condition of Patient/Client:</b>
A.	What is the diagnosis/impairment?
B.	When was the diagnosis originally made?
C.	Is the patient/student currently under your care?
D.	When did you last see the patient/student?
E.	Is the impairment temporary (< 3months) or persistent?
F.	Please identify any factors that may affect the severity of the impairment (e.g., to what degree might the impairment be <i>minimized</i> by medications, hearing aids, etc.?) Alternatively, could there be an adverse effect (e.g., medication side effects)?

<b>3. Please complete the following:</b>		<b>FUNCTIONAL IMPACT ASSESSMENT</b>									
<b>LIMITATION IS:</b>		<b>1 =Unable to Determine</b>			<b>2 = Mild</b>			<b>3 = Substantial</b>			
<b>1</b>	<b>2</b>	<b>3</b>	<b>Major Life Activity</b>		<b>1</b>	<b>2</b>	<b>3</b>	<b>Major Life Activity</b>			
			Caring for oneself					Learning			
			Talking					• Reading			
			Hearing					• Writing			
			Breathing					• Spelling			
			Seeing					• Calculating			
			Walking/Standing					• Concentrating			
			Lifting/Carrying					• Memorizing			
			Sitting					• Listening			
			Performing Manual Tasks					Other:			
			Eating								
			Working								
			Interacting with Others								
			Sleeping								

**4. What method(s) were utilized to assess functional limitation? Please list or attach under separate cover.**

**5. Please list your recommendations for accommodations within the academic environment. Please provide a rationale for any recommendation made utilizing data from objective measures, the educational record, or other data sources. Please list or attach under separate cover.**

**6. Certifier Information:**

Clinician  
Name \_\_\_\_\_

Medical  
Specialty \_\_\_\_\_

License \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Please send this completed form and any additional information to: **Office for Disability Services, Lincoln College - Normal**

Mail: 715 W. Raab Rd., Normal, IL 61761. Phone: (309) 268-4321 Fax: (309) 454-5652 Email: [ncods@lincolncollege.edu](mailto:ncods@lincolncollege.edu)

If you have questions, please feel free to contact our office. Thank you.