TEXAS A&M UNIVERSITY
CORPUS CHRISTI

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

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.*

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.

_____

_____

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.