CAAS

Center for Access and Accommodative Services

Center for Access and Accommodative Services
Triton College
2000 Fifth Ave., River Grove, IL 60171, Room A-125
Phone: (708) 456-0300, Ext. 3853 or 3854, Fax: (708) 456-0991

MEDICAL DISABILITY DOCUMENTATION

The student, whose name and signature appear below, has requested accommodative services based on the diagnosis of a medical condition. Students requesting services from the Triton College Center for Access and Accommodative Services are required, under Section 504 of the Federal Rehabilitation Act of 1973, to submit documentation to verify eligibility for academic accommodations. This form must be completed by a licensed physician. **Please complete and return this form in a sealed envelope or by fax to the attention of C.A.A.S.**

Please note: Accommodations will be provided only upon receipt of complete and adequate documentation.

Student Name	**Signature**	**Birth Date**

Physician Name	**Office Phone**	**License Number**

Office Address	**Town**	**Zip Code**

Diagnosis/health condition:

ICD CODE	DIAGNOSIS

Description of the functional impact of the medical condition/disability. (Include a description of functional impact on physical, perceptual, and cognitive abilities.)

MEDICATION	DIAGNOSIS	SIDE EFFECTS

Is this person undergoing treatment for a medical condition that would cause them to be absent from class on a regular basis, such as chemotherapy, infusion therapy, etc.? Please explain:

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Date of original diagnosis: _____ **Date of current diagnostic evaluation:** _____

Treatment, medications, assistive devices/services currently prescribed. (Include significant side affects of medication and therapies that may impact physical, perceptual or cognitive performance.)

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Progression or stability of the impact of the medical condition/disability over time. (List estimated changes in functional limitations that may occur over time that may warrant reevaluation of services.)

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Recommendations for accommodations and/or support services.

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I RECOMMEND THE FOLLOWING COURSE LOAD:					
	Minimal part time		**Part time**		**Full time**
_____	**1 Class**	_____	**2-3 Classes**	_____	**4-6 Classes**
_____	**Approximately 3-5 credit hours**	_____	**Approximately 6-9 credit hours**	_____	**Approximately 12-15 credit hours**

I certify that the above stated information is correct based on my professional judgment

Physician Signature _____ **Date** _____