Office of Accessibility & Accommodations
Eastern Illinois University
600 Lincoln Avenue
Charleston IL 61920-3099
217-581-6583 (Voice/TTY)
217-581-7208 (Fax)

PHYSICIAN'S STATEMENT TO DETERMINE ELIGIBILITY FOR A FUNCTIONAL OR PHYSICAL IMPAIRMENT

Student Information

Student Name:

Student EIU E Number:

The above named individual is a student at Eastern Illinois University. S/he is requesting support services/accommodations for a physical or functional disability. The University is committed to providing reasonable accommodations and academic support to all students who have a disabling condition as defined by federal legislation (the 1973 Rehabilitation Act [Section 504] and the 1990 Americans with Disabilities Act). University policy requires that students requesting such assistance provide verification of disability from the student's attending physician. The documentation must be submitted to Office of Accessibility & Accommodations in a reasonable amount of time for the University to provide the necessary accommodations.

Under the Americans with Disabilities Act, an individual with a disability is any person who:

1) Has a physical or mental impairment which substantially limits one or more major life activities;
2) Has a record of such impairment; or,
3) Is regarded as having such an impairment.

Diagnoses: _____
_____
_____
_____

Date of initial diagnosis:	
Date of last of visit:	
How often do you meet with this individual?	
Frequency of episodes:	
Severity of episodes:	
Dates of hospitalizations and emergency rooms visits for this condition:	

What situations are likely to immediately trigger an episode of this condition (e.g. low sugar levels, smoke, etc.)?

_____
_____
_____

What repetitive situations are likely to trigger an episode of this condition?

_____
_____
_____

Current treatment for this condition:

_____
_____
_____

List any medication(s) prescribed and side effects experienced:

_____
_____
_____

Please check all major life activities that are affected by this condition:

□ breathing □ walking □ hearing □ seeing □ working □ learning
□ performing manual tasks □ caring for oneself □ no major life activities are affected

What are the functional limitations of the disability?

_____
_____
_____

Please list pertinent testing that helps to confirm diagnosis:

Test_____	Date: _____	Results: _____
_____	_____	_____
_____	_____	_____

Please attach medical information that is needed to substantiate a disability and the need for accommodations (i.e., current medical records, additional copies of test results etc.)

Certifying Medical Physician Information

Physician Name:

Physician Signature:

Medical Specialty:

License/Certification Number

Address:

Phone:

Email:

Date:

EIU Contact Information

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