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

Section I. To be completed by the student.

Name _____ Student ID# _____

Address _____

Phone _____ Date of Birth _____

Physician or Appropriate Professional:_____

Phone: _____

Address:_____

_____

I request and authorize the release of the information provided 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.

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.:

_____

_____

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

:_____

_____

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.

_____

_____

IV. Certification by Qualified Professional

_____

Name (Typed or Printed) Signature

Address _____

City _____ State _____ Zip _____

Date _____ License Number _____