Access Center Disability Services
Disability Medical Assessment Form

To Whom It May Concern:

This patient/client is seeking to receive academic accommodations through the Access Center at Century College. In order to ensure reasonable and appropriate accommodations, sufficient documentation must be provided by a medical professional, who can verify a disability, which is defined as an impairment that substantially limits one or more major life activities. To facilitate the implementation of accommodations, we ask that you provide the following information.

Please Complete the Following:

1. Patient/Client Name:

2. The Condition of the Patient/Client:

   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   b. When was the diagnosis originally made?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 (<3 months) or permanent?

   f. Please identify and factors that may affect the severity of the impairment (e.g., to what degree might the impairment be minimized by medications, hearing aids, etc.?) Alternatively, could there be an adverse effect (e.g., Medication side effects?)

3. Please Complete the Following:

Functional Impact Assessment

Limitation Is: 1=Unable to Determine 2=Mild 3=Substantial

Major Life Activities:			
Caring for Oneself			
Talking			
Hearing			
Breathing			
Seeing			
Walking/Standing			
Lifting/Carrying			
Sitting			
Performing Manual Tasks			
Eating			
Working			
Interacting with Others			
Sleeping			
Learning in General:			
Reading			
Writing			
Spelling			
Calculating			
Concentrating			
Memorizing			
Listening			
Other:			

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 if necessary.

6. Certifier Information:

   Clinician Name: ____

   Medical Specialty: ____

   License: ____

   Address: ____

   ____

   Phone: ____

   Email: ____

   Please send this completed form and any additional information to:

   Access Center
   Century College
   3300 Century Ave.
   W2440
   White Bear Lake, MN 55110

   Phone: 651-779-1745
   Fax: 651-779-5831
   Email: Access.Center@century.edu