

PROFESSIONAL CERTIFICATION

California State University, Stanislaus
Disability Resource Services
209-667-3159
TDD 209-667-3044

(Please Print or Type)

PATIENT'S NAME: _____ Birth Date: _____
Last First Middle

1. Specific diagnosis: _____

2. Prognosis: Permanent _____ Temporary (expected duration) _____

3. Does this disability seriously limit mobility: YES _____ NO _____
If yes, indicate how limited: Fatigue ____ Physical Limitations ____ Pain ____ Other ____

4. Describe specific functional limitations, i.e. how does the disability substantially limit major life functions (walking, breathing, writing, performing manual tasks, seeing, hearing, information processing, etc.) NOTE: Giving percentage of disability will not be accepted without naming specific limitations.

5. Assistive devices used by applicant: _____

SERVICE(S) RECOMMENDED: Handicapped parking ____ Writer ____ Reader ____
Notetaker ____ Extra time for exams ____
Other (specify) _____

Professional's Name Signature License No.

Address Phone Date

Please indicate your professional affiliation: Physician ____; LCSW ____; MFT ____; physical therapist ____; registered nurse ____; speech pathologist ____; or other appropriate professional (please specify) _____.

THE DISABILITY RESOURCE SERVICES OFFICE AT CALIFORNIA STATE UNIVERSITY, STANISLAUS RESERVES THE RIGHT TO MAKE FINAL DETERMINATION CONCERNING ELIGIBILITY AND CONTINUATION OF SERVICES.