Office of Disability Services
disability@centenary.edu

Disability Certification Form
Academic Accommodations

To be completed by the student's physician/provider – this form is to be filled out in its entirety.

Patient's Name: _____ Date of Birth _____/_____/_____

Today's Date: _____/_____/_____

1. Please state the complete diagnosis that supports the disability:

_____

_____

2. How did you arrive at your diagnosis? Please check all relevant items below; adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student:

- ☐ Structured or Unstructured Interviews
- ☐ Interviews with other persons
- ☐ Behavioral Observations
- ☐ Medical Tests
- ☐ Medical History
- ☐ Developmental History

3. Date of Diagnosis: _____/_____/_____
4. This student has been under a physician/provider's care since: ____/____/_____
5. Date student was last seen (prior to today): _____/_____/_____
6. How long is this condition likely to persist? _____
7. How often is the student required to check-in with a physician? Circle one:

Once a week — Once a month
Every 3-4 months — Every six months
Once a year — As needed
Other: _____

8. What medication(s) is the student currently taking?

Name: _____	Dose: _____	Times Per Day: _____
Name: _____	Dose: _____	Times Per Day: _____
Name: _____	Dose: _____	Times Per Day: _____
Name: _____	Dose: _____	Times Per Day: _____

9. How effective is the medication? How might side-effects, if any, affect the student's academic performance?

_____

_____

_____

_____

10. Please check which of the major life activities listed below are affected because of the disability diagnosis. Please indicate the level of impact/limitation.

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Memory	☐	☐	☐	☐
Concentration	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self-care	☐	☐	☐	☐
Waiting/Standing	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐
Mobility problems	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Seeing	☐	☐	☐	☐
Managing Internal Distractions	☐	☐	☐	☐
Managing External Distractions	☐	☐	☐	☐
Timely submission of assignments	☐	☐	☐	☐
Attending class regularly and on-time	☐	☐	☐	☐
Making and keeping appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Organization	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

11. What other specific symptoms manifesting themselves at this time might affect the student's academic performance?

_____

_____

_____

_____

12. How long do you anticipate that the student's academic performance/achievement will be impacted by their disability?

Circle one: 6 months 1 year 1-2 years Permanently Unknown

13. Is there anything else you think we should know about the student's condition?

_____

_____

_____

_____

Name/Title (printed): _____

Signature: _____

License/Certification Type: License #: _____

State of Licensure: _____ Phone Number: _____

Please return to student or send directly to:
Office of Disability Services – Centenary College
2911 Centenary Blvd.
Shreveport, LA 71104
Phone: 318-869-5738 Fax: 318-869-5129

disability@centenary.edu