Academic Center for Excellence
MEDICAL DISABILITY DOCUMENTATION

CONCORDIA UNIVERSITY CHICAGO
1864

The student whose name appears below is seeking accommodations based on the diagnosis of one or more disabilities. The student is requesting that the documentation of the diagnosis be provided to the Academic Support Coordinator at Concordia University Chicago. Documentation is required to verify the student's eligibility for accommodations under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990. This form must be completed by an appropriate licensed medical provider. Additional information, such as reports of testing results, may be appended to this form. All materials should be returned to the Academic Center for Excellence (ACE) Office:

Mail: **Academic Center for Excellence (ACE)**
Christopher Center 248
Concordia University Chicago
7400 Augusta Street
River Forest, Illinois 60305

Email: ACE@CUChicago.edu

STUDENT'S IDENTIFICATION INFORMATION

Name: _____ Birthdate: _____ H Number: _____

MEDICAL PROVIDER'S INFORMATION

Name: _____ Credentials: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone Number: _____ Professional License Number: _____

STUDENT'S MEDICAL INFORMATION

Primary diagnosis/health condition:

Date of original diagnosis: _____ Date of current evaluation: _____

Other diagnosis/health conditions:

Form continued on page 2.

MEDICAL DISABILITY DOCUMENTATION (cont.)

Description of the functional impact of the medical condition or disability on physical, perceptual, and cognitive abilities, including any specific motions or physical exercises this student cannot perform:

Treatment, medications, assistive devices/services currently prescribed:

Significant side effects of medication and therapies that may impact physical, perceptual or cognitive performance:

Progression or stability of the impact of the medical condition/disability over time (list estimated changes in functional limitations that may occur over time that may warrant reevaluation of services):

Describe suggested accommodations and state how each would improve education access for this student:

I certify that the information stated above is correct based on my professional judgment.

Licensed Medical Provider's Signature

Date