Revised 6/2017

JOLIET JUNIOR COLLEGE
1901
1215 Houbolt Road ▪ Joliet, IL 60431

DISABILITY SERVICES
(815) 280-2230 or (815) 280-2941 ▪ Office A-1125

MOBILITY, UPPER EXTREMITY, SYSTEMIC/CHRONIC HEALTH, AND OTHER FUNCTIONAL IMPAIRMENTS DOCUMENTATION

Date: _____ Date of Birth: _____

Name of Student: _____

Dear Medical Professional:
The student whose name appears above has applied for services from the Disability Services Office at Joliet Junior College. In order to provide disability-related services, we need to establish this student has a disability. A disability is defined as impairment substantially limiting a major life activity. Please assist the student by completing the information below. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

Impairment Assessment:

1. What is the diagnosis/impairment?

   _____

2. Date of original diagnosis:

   _____

3. Is the patient/student currently under your care?

   _____

4. When did you last see the patient/student?

   _____

5. Is the impairment temporary (<6 months) or persistent?

   _____

6. Medications and possible side effects:

   _____

Major Life Activities Assessment:

Please check any of the major life activities listed below that are affected as a result of the impairment. Please indicate the level of limitation.

	Negligible	Moderate Impact	Substantial Impact	Don't Know
Caring for oneself				
Talking				
Hearing				
Breathing				
Standing				
Working				
Reaching				
Lifting				
Sitting				
Walking				
Seeing				
Writing				
Performing manual tasks				
Sleeping				
Learning				
Reading				
Thinking				
Concentrating				
Memorizing				
Taking exams				
Interacting with others				
Other: (explain)				

What are the functional limitations resulting from the impairment's impact on major life activities identified in #2 above?

_____

_____

_____

_____ _____

Signature of Professional Date

_____ _____

Health Professional's Name (printed) and Title License Number

_____ _____

Clinic Name and Street Address Telephone Number

_____ _____

City, State, Zip Code Fax Number