



JOLIET JUNIOR COLLEGE

1215 Houbolt Road • Joliet, IL 60431

1901

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