THE MASTER'S
UNIVERSITY

Documentation Form for Students with Medical Conditions

The student named below has applied for services from the Office of Disability Services at The Master's University. In order for the Office of Disability Services to establish whether this student has a disability and to determine eligibility for services we will need your assessment and diagnosis of this student. A disability is defined as a physical or mental impairment that limits one or more major life activities such as those delineated below. You can fax or mail the form to us at the address listed on this form. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

TODAY'S DATE: ____

STUDENT'S NAME: ____

DATE OF BIRTH: ____
MONTH DATE YEAR

What is the diagnosis/impairment?

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What is the date of diagnosis/impairment?

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Major Life Activities Assessment: Please use a checkmark to indicate the disability's impact, if any, on the activities listed below, and describe the impact if appropriate.

LIFE ACTIVITY	NO IMPACT	MODERATE IMPACT	SEVERE IMPACT	DON'T KNOW	PLEASE DESCRIBE IF MODERATE OR SEVERE IMPACT
Walking (e.g. how far/long can student walk, use of mobility devices such as wheelchair, etc.)					
Standing (e.g., duration)					
Sitting (e.g., duration)					
Performing manual tasks (e.g., reaching, manipulating materials & lab equipment, etc.)					
Writing/Keyboarding (e.g., unable to keyboard more than 10 min., unable to handwrite, etc.)					
Speech Impairment					
Breathing					
Sleeping (or attach most recent sleep study)					
Caring for oneself (e.g., personal care, laundry, household tasks, etc.)					
Hearing (or attach most recent audiogram)					
Vision (or attach most recent eye exam)					
Learning					
Reading					
Concentrating					
Communication					
Other					
Extra comments					

Please describe the effect of the medical condition, including side effects and/or pain symptoms, on academic performance (e.g., concentration, reading, thinking, learning, etc.) and attendance.

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Please list medications and possible side effects on academic performance and attendance.

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If student is undergoing treatment, please describe how treatment (e.g., frequency of treatments, side effects of treatments, etc.) may affect student's performance and attendance.

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Will the functional limitations last for the duration of the student's matriculation at The Master's University?
Yes ____________ No ____________

If functional limitations fluctuate, how frequently did the student experience flare-ups within the past 12 months or since onset of diagnosis?

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When and/or how often should the student be evaluated? Or, if limitations are not permanent, when will the injury be resolved?

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Please attach any relevant supporting documentation

Recommendations for accommodations

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Certifying Medical Professional

Signature of Medical Professional ______________________________ Date ______________________

Medical Professional's Name (printed) ______________________________ Date ______________________

Address ______________________________ Telephone Number ______________________

City, State Zip ______________________________ Fax ______________________

Mail, email or fax forms to:

Office of Disability Services, The Master's University
Attn: Kara Antariksa, Manager of Disability Services
21726 Placerita Canyon Road
Santa Clarita, CA 91321

Kantariksa@masters.edu
FAX: 661-362-2668