BROWARD COLLEGE | ACCESSIBILITY RESOURCES

North Campus
1000 Coconut Creek Blvd., Coconut Creek, FL 33066
Phone 954-201-2313 | Fax 954-201-2489

Physical, Sensory, and other Medical Disorders Verification Form

Student Name and ID Number: _____

Date of Birth: _____ Phone: _____ BC Email: _____

The following information is to be completed by a qualified health professional and either returned directly to Accessibility Resources or the student. This information will be used to assist Broward College in determining appropriate accommodations.

Specific Diagnosis (one per form) _____

Date of Diagnosis _____

How long has the student been your patient? _____

Prognosis: Permanent Temporary **How long?** _____

Severity: Mild Moderate Severe

Fine Motor Skills (check one): ____ Needs assistance with writing ____ Can write but needs additional time
____ No writing assistance needed

Is there an indication of problems with pain _____ or fatigue _____?

Current medications	Side effects
_____	_____
_____	_____
_____	_____
_____	_____

How does this student's disability affect them in an educational setting?

_____

_____

If this is a **visual** or **hearing** disability, please respond to the following:

Visual Acuity/Low Vision: Please attach test results.

Hearing: ASL interpreter required? ____ Yes ____ No Please attach an audiogram and any additional information.

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Physical Ability Assessment

Student Name and ID Number: _____

Please mark all areas that apply to this student's physical disability limitations.

Lifting Upper Body
No limitations:
Maximum lbs.:

Pushing
No limitations:
Maximum lbs.:

Pulling
No limitations:
Maximum lbs.:

Grasping
No limitations:
Maximum lbs.:

Reaching
No limitations:
Maximum lbs.:

Climbing
No limitations:
Limitation:

Carrying
No limitations:
Maximum lbs.:

Lifting Lower Body
No limitations:
Maximum lbs.:

Sitting
No limitations:
Maximum time:

Standing
No limitations:
Maximum time:

Crouching
No limitations:
Limitation:

Kneeling
No limitations:
Limitation:

Walking
No limitations:
Limitation:

Running
No limitations:
Maximum time:

_____ _____
Physician's Signature Date

_____
Print Name, Title, License Number

_____
Address and Phone Number