Mount St. Joseph University
Documentation for Temporary Illness, Injury, Pregnancy or Related Condition

Specialists Name _____
Medical Specialty _____
Address _____
Phone Number _____ Email_____

One of your patients is a student at Mount St. Joseph University. He/she has requested academic modifications based on a serious, but temporary, illness, injury, pregnancy, or pregnancy related condition. In order to be considered for such modifications, a student must provide documentation that attests to the fact that he/she has an impairment, or pregnancy or pregnancy related condition, that is significantly affecting his/her class attendance or functioning in the classroom.

Patient name_____ DOB___/___/____

Diagnosis:_____

Prognosis:_____

FUNCTIONAL IMPACT ASSESSMENT

LIMITATION IS ***1=Substantial*** ***2=Mild*** ***3=Unable to Determine***

1	2	3	Major Life Activity	1	2	3	Major Life Activity
			Caring for oneself				Learning
			Talking				• Reading
			Hearing				• Writing
			Breathing				• Spelling
			Seeing				• Calculating
			Walking/Standing				• Concentrating
			Lifting/Carrying				• Memorizing
			Sitting				• Listening
			Performing Manual Tasks				Managing Time
			Eating				Organizing
			Working				Other
			Interacting With Others				
			Sleeping				

Recommended modifications based on patient's physical limitations

Anticipated timeframe for modifications ___/___/___ to ___/___/___

Is it medically safe for this patient to attend class? Yes___ No___
Reason:_____

Estimated date of return ___/___/____

Signature **Date**