Return form and relevant documentation to:
Office of Student Accessibility Services
Illinois Wesleyan University
PO Box 2900, Bloomington, IL 61702-2900
accessibility@iwu.edu
309-556-3231 (phone), 309-556-3436 (fax)

Temporary Medical Condition Verification

The Office of Student Accessibility Services provides support to students with temporary medical conditions as a result of injuries, surgeries, or significant illnesses. Although these students are not eligible for formal accommodations, they may benefit from services that the office can coordinate, such as extra time for examinations, note taking support, or accessible housing/classrooms.

To determine eligibility for services, current and comprehensive documentation (outlined below) of the illness/injury is required from the diagnosing/treating physician or other appropriate medical professional. Once this form is received, the Director of Student Accessibility Services will distribute an email to the appropriate faculty members regarding temporary accommodations. *Individual faculty members have discretion as to whether allowances will be made for missed classes and/or fulfilling course requirements (e.g., examinations, presentations, participation) due to a temporary medical condition.*

Student Name: _____

Date of Birth _____ IWU ID #: _____

STUDENT - PLEASE READ AND SIGN:

By signing this form, I understand that my current faculty members and academic advisor will be notified of my temporary medical condition, and that it is my responsibility to discuss my temporary accommodation needs in their courses.

Signature _____ Date: _____

1. Diagnosis, injury, and/or condition (based on formal assessment by a qualified provider):

2. Date of diagnosis, injury, and/or condition and last contact with the student?

3. Treatments, medications, devices, or services currently prescribed or used to minimize the impact of the illness/injury:

4. The expected duration, stability, or progression of the illness/injury:

5. Provide a clear description of the recommended accommodation(s) with rationale:

6. Check any areas of functioning impacted by the illness/injury, explain the limitation, and circle the degree of limitation:

Area of functioning (check)	*Limitation on Functioning (explain)*	*Degree of limitation (circle)*
☐ Hearing		Mild Moderate Severe
☐ Vision		Mild Moderate Severe
☐ Speech		Mild Moderate Severe
☐ Manual Dexterity		Mild Moderate Severe
☐ Ambulation		Mild Moderate Severe
☐ Motor Coordination		Mild Moderate Severe
☐ Cognitive Skill		Mild Moderate Severe
☐ Other		Mild Moderate Severe

I verify that the above-named student information is correct, the student is a patient or client that I have been treating, and I am not a relative of the student.

Print name and title: _____

Signature _____ Date: _____

Address: _____

Telephone: _____ Email: _____