



JOLIET JUNIOR COLLEGE

1901

1215 Houbolt Road • Joliet, IL 60431

DISABILITY SERVICES

Phone: 815-280-2613 • Fax: 815-280-2820 • Office: A-1125 • Disabilityservices@jjc.edu

DISABILITY DOCUMENTATION

Date: _____ Date of Birth: _____

Name of Student: _____ Date of last visit: _____

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 verify the presence of a disability and determine the student's eligibility for services, we need your assessment and diagnosis of this student. Please complete this form, or you can answer these questions in a signed and dated letter on your professional letterhead.

1. Diagnosis and/or Impairment

Date of Diagnosis: _____ Temporary or Chronic: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

2. What were the assessment or evaluation procedures used to make the diagnosis?

3. Briefly describe as appropriate the history of presenting symptoms and past functioning, duration of the disability, and relevant development, or historical data pertinent to the disability.

4. What is the current prognosis?

5. What are the major symptoms of the disorder currently manifested by the patient/student, including level of severity?

6. Which medication(s) is the individual currently taking; are there any substantial side effects for this medication(s)?

7. Is this student a danger to himself or others?

Please check each of the major life activities listed below that are affected by the disorder. Please indicate the severity of limitations.

Life activity	No Impact	Moderate Impact	Substantial Impact	Unknown
Concentration				
Memory				
Social Interactions				
Time management				
Motivation				
Performing Manual Tasks				
Organization				
Caring for oneself				
Stress Management				
Sleeping				
Eating				
Talking				
Hearing				
Seeing				
Breathing				
Standing				
Walking				
Lifting				
Sitting				
Learning				
Writing				
Reading				
Other:				

Signature of Professional

Date

Professional's Name (printed) and Title

License Number

Street Address

Telephone Number

City, State, Zip Code

Fax Number

