

Campus Disability Resource Center

Student ADA Medical Certification Form

Cal Poly Humboldt has received notice from our student indicating that they have a condition or disability that requires an accommodation in the academic setting. To process this request and provide academic accommodations, additional information is needed from you as their identified treatment provider.

All medical information shall be kept confidential and maintained as part of their educational record and protected under the [Family Educational Rights and Privacy Act \(FERPA\)](#)¹ and/or the [Health Insurance Portability and Accountability Act \(HIPAA\)](#)². First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Student Information

* Indicates required field

Name: *

Humboldt ID#: *

Address: *

City: *

State: *

Zip Code: *

Phone:

Humboldt Email: *

Student Signature: *

Date Signed: *

¹ Family Educational Rights and Privacy Act (FERPA): <https://registrar.humboldt.edu/privacy>

² Health Insurance Portability and Accountability Act (HIPAA): <https://www.hhs.gov/hipaa/index.html>

REMAINDER OF FORM TO BE COMPLETED BY PRACTITIONER

Disability or Condition Information

1. Describe the (a) nature, (b) severity, and (c) duration of the student's disability or condition. If the disability or condition is temporary, indicate the end date of the temporary disability or condition. *

2. Does the disability or condition substantially limit a major life activity? * Yes No

If yes, please check the major life activity or activities that apply:

Bending	Learning	Sitting
Breathing	Lifting	Sleeping
Caring for Self	Performing Manual Tasks	Speaking
Concentrating	Reaching	Standing
Eating	Reading	Thinking
Hearing	Seeing	Walking
Interacting with Others		Working
Other (please describe):		

3. Does the disability or condition substantially limit a major bodily function? * Yes No

If yes, check the major bodily function or functions that apply:

Bladder	Immune
Bowel	Lymphatic
Brain	Musculoskeletal
Cardiovascular	Neurological
Circulatory	Normal Cell Growth
Digestive	Operation of an Organ
Endocrine	Reproductive
Genitourinary	Respiratory
Hemic	Special Sense Organs & Skin
Other (please describe):	

4. Disability effects on academic performance: *

Distractibility

Impaired Motor/Mobility Function

Decreased Concentration

Fatigue

Confusion/Thought Disorder

Chronic Pain

Impaired Memory

Other:

5. Are there disability or accessibility needs required in University Housing? If so, describe and elaborate:

6. Are there any medication-related functional effects that could impact academic performance?

Functional limitations are substantial limitations in an individual's ability to perform tasks related to academic performance.

Name of Drug	Purpose of Medication

Medication's Effects on Academic Performance:

Confusion/Thought Disorder

Sedation/Fatigue

Decreased Concentration

Agitation

Impaired Coordination

Distractibility

Psychomotor Retardation

Other:

Section 4: Licensed Practitioner Information

Name: *

License Number: *

Type of License: *

Address: *

City: *

State: *

Zip Code: *

Phone Number: *

Fax Number: *

Provider Signature: *

Date: *

**** This form will not be accepted without signature from practitioner ****