Please note: A clinician with expertise in the area of the condition following best practices in the field and not related to the student should complete this form.

In order for us to provide disability-related services and accommodation, we need to establish that this individual has a physical or mental impairment that limits one or more of the major life activities, understand the impact of that disability in higher education settings, and determine reasonable accommodations and services that may assist in ameliorating these impacts. Complete documentation guidelines are available at: http://accessibility.jhu.edu/accommodations/

Today’s Date: _____________________

Individual’s Name: _____________________________________ JHU School: _______________________

Student Status (Circle):    Undergraduate     Graduate     Medical      Other: __________________________

Diagnosis/Description of the Functional Impact

1. Please state the condition/diagnosis:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

2. How did you arrive at your diagnosis? Please check all relevant items below:

Structured or Unstructured interview □     Medical tests □
Interviews with others □      Medical History □
Behavioral Observations □   Developmental History □

3. Describe the relevant, current impact of the condition on the student in a higher education setting (academic, housing, dining, transportation, social, etc).

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
### History and Prognosis

<table>
<thead>
<tr>
<th>Date condition was first diagnosed</th>
<th>Month</th>
<th>Date</th>
<th>Year</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date individual first seen for the condition</td>
<td></td>
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<tr>
<td>Date most recently seen for this condition</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Expected duration of condition</td>
<td></td>
<td></td>
<td></td>
<td>Permanent</td>
</tr>
<tr>
<td>How long do you anticipate the impact</td>
<td>3 months</td>
<td>6 months</td>
<td>1 year</td>
<td>More than one year</td>
</tr>
<tr>
<td>Anticipated return to work date</td>
<td></td>
<td></td>
<td></td>
<td>TBD at a later date</td>
</tr>
<tr>
<td>The condition is</td>
<td>stable</td>
<td>improving</td>
<td>worsening</td>
<td>cyclically variable</td>
</tr>
<tr>
<td>The prognosis is</td>
<td>poor</td>
<td>fair</td>
<td>good</td>
<td>excellent</td>
</tr>
<tr>
<td>How often is this individual seen</td>
<td>weekly</td>
<td>monthly</td>
<td>3-6 months</td>
<td>yearly</td>
</tr>
</tbody>
</table>

4. If the individual is currently taking medication that has side effects and any impact on functioning, please describe below. Do limitations/symptoms persist even with medications?

<table>
<thead>
<tr>
<th>Medication and Dosage</th>
<th>Side Effects</th>
<th>Academic/Work Impact</th>
<th>Persistence of Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

5. Please list any specific accommodations or services to address the functional limitations identified.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

6. Do you anticipate any changes in the individual’s condition/medication? No Yes Please explain.
__________________________________________________________________________________
7. Is the individual working with another physician or specialist to treat the condition(s)?  No  Yes
Please explain and indicate who else if known.
__________________________________________________________________________________
__________________________________________________________________________________

8. Is there anything else you think we should know about the individual or their condition?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

PLEASE TYPE OR PRINT CLEARLY

Name/Title __________________________________________________________________________

Signature______________________________________________ Date: _____________________

License/Certification #____________________________________   State ______________________

Address _________________________________________________________________________
City, State, Zip Code_______________________________________________________________

Phone _______________________________   Fax _____________________________________

Additional information can be submitted in a signed, typewritten letter on letterhead.

Documentation must be returned to Disability Support Services staff at the Johns Hopkins Bloomberg
School of Public Health, by FAX 410-502-9809, email JHSPH.dss@jhu.edu, or by mail to: 615 N. Wolfe
Street, Suite W1600, Baltimore, MD  21205.