PEMBERTON TOWNSHIP SCHOOL DISTRICT
SECTION 504 ACCOMMODATION(S) PHYSICIAN CERTIFICATION FORM

STUDENT NAME: _____ DATE OF REQUEST: _____
GRADE:_____ SCHOOL:_____

TO BE COMPLETED BY PHYSCIAN/PSYCHIATRIST/PSYCHOLOGIST

A. DISABILITY

1. Does student have a mental or physical impairment? ☐ Yes ☐ No
   If yes, specify the mental or physical impairment of the child.
   _____

2. Does the mental or physical impairment stated in A.1. substantially limit one or more major life activities? _____

   If yes, check the **major life activity** impacted by the mental or physical impairment.

   ☐ Breathing ☐ Hearing ☐ Walking ☐ Learning ☐ Speaking

   ☐ Seeing ☐ Lifting ☐ Standing ☐ Sitting ☐ Working

   ☐ Performing manual tasks ☐ Caring for Oneself

   ☐ Other If Other please specify _____

3. State the approximate date the condition commenced and the probable duration of the condition _____

4. Is the condition a chronic condition _____

5. Is the child required to receive any type of treatment for his/her condition? If so, please describe the treatment below:

   _____
   _____
   _____
   _____

6. Place an "X" on the following scale to indicate the specific degree that the impairment stated in item A.1. limits the major life activity checked in A.2.

Guideline In Completing Scale

- An impairment substantially limits a major life activity if the individual is unable to perform or is significantly limited in the ability to perform the activity compared to an average person in the general population. Factors to consider are: nature and 'severity of the impairment; how long it will last, or is expected to last; and its permanent or long-term impact or expected impact.

- Use the average student in the general population as the frame of reference for purpose of comparison.

- Temporary, non-chronic impairments that do not last for a long time and that have little or no long term impact usually are not disabilities. Consider extent, duration and impact of the impairment.

Scale

For an "X" at 4.0 or above, fill in specific information evaluated by the committee that justifies the rating:

5 ___ Extremely _____

4 ___ Substantially _____

3 ___ Moderately _____

2 ___ Mildly _____

1 ___ Negligibly _____

B. SUMMARY

1. Does the student have a DISABILITY? ☐ Yes ☐ No

2. Is the student a QUALIFIED INDIVIDUAL? ☐ Yes ☐ No

3. What accommodation(s), if any, are you recommending for this student in school:

_____

_____

_____

I hereby certify that the information contained herein is accurate and truthful. I further understand and certify that if any of the statements contained therein are willfully false, I am subject to punishment.

Physician's signature/stamp	Date
(Area of Medical Specialization)	Telephone Number