UNMC
BREAKTHROUGHS FOR LIFE.

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MEDICAL EVALUATION

First Name: _____ Last Name: _____

NU ID: _____ Date of Birth: _____

College/Program: _____

I have reviewed the medical status of this student. I have conducted an exam for the purpose of assessing whether the student has a physical, psychological, sensory, or learning disability, the impact of said disability, if any, on major life activities, and which accommodations may be reasonable concerning the student's ability to participate in their academic program or an activity at the University of Nebraska Medical Center. The answers provided below, and any additional statements made, reflect my medical judgment concerning the status of this student.

1. Have you diagnosed this student with a disability?

☐ Yes ☐ No

If yes, please provide a detailed diagnosis:

2. What functional limitation(s) is/are interfering with the student's ability to participate in the program or activity at issue?

3. Which aspect(s) of the program or activity at issue is/are the student unable to perform because of the limitation(s)?

4. Do you know of any accommodation(s) that might help the student participate effectively in the program or activity at issue?

   ☐ Yes ☐ No

   If yes, please explain the nature of the recommended accommodation(s) in detail.

5. Does the student have any physical or mental impairment that would create a current, significant risk of serious harm to themselves or others if they participate in the program or activity at issue?

   ☐ Yes ☐ No

   If yes, please explain in detail.

6. In considering whether the student poses a significant risk of serious injury or death to themselves, I have considered the following:

   a. The severity of harm ☐ Yes ☐ No

   b. The likelihood of an accident or other cause of harm occurring ☐ Yes ☐ No

   c. The imminence of the potential harm (not just a speculative risk) ☐ Yes ☐ No

Please print or type:

Provider Name: _____

Title or Professional Designation: _____

Highest Academic Degree: _____

Board Certification or Specialty: _____

Complete Address: _____

Phone: _____ Fax: _____

Email: _____

Signature of Provider: _____ Date: _____