DES MOINES UNIVERSITY
MEDICINE & HEALTH SCIENCES

Center for Educational Enhancement – Academic Support • accommodations@dmu.edu • 515-271-1516

Clinical Checklist for Accommodations

Student Approval for Release of Information

I am requesting academic support services through the Center for Educational Enhancement – Academic Support at Des Moines University. They require current and comprehensive documentation to evaluate my eligibility for disability related accommodations or services. Please respond to the following questions as soon as possible and return to me or send to an Accommodations Specialist by email accommodations@dmu.edu.

I authorize the Accommodations Specialist at DMU to contact your office for clarifying information if needed.

Student name: _____ Birthdate: _____
Student Signature: _____ Date: _____

Provider section

Provider name (print): _____Title _____

Phone: _____ Fax: _____

Organization name: _____

Organization address: _____

TYPE OF INJURY OR CONDITION

☐ Arm, Hand, Leg, or Foot
☐ Head
☐ Biological
☐ Other (list): _____

Full description and nature of the condition:

Date of onset: _____ Anticipated date of recovery: _____

Date of next professional follow-up visit: _____

Table 1: Medications taken for condition

Medication name	Rx or OTC	Dose	Frequency	Start Date	Reason for taking

Relevant side effects: _____

Table 2: Impact on function in several areas.
Include sensory (seeing, hearing), physical (walking, lifting), mental (reading, concentrating), or other (social, attendance).

Area	None	Mild	Moderate	Substantial
1. gg	☐	☐	☐	☐
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐

Table 3: Current symptoms

Symptom	Frequency	Duration	Intensity

Can student perform timed tasks?
☐ Yes
☐ No
☐ Limited: _____

Restrictions or functional limitations due to the condition:

RECOMMENDATIONS

Additional information, recommendations, and **suggested accommodations**:

Physician Signature: _____ Date: _____