RIVERSIDE TOWNSHIP PUBLIC SCHOOLS

Physician Certification for Pupil Disability Accommodation

____ ______________________
Print Patient Name (last, first, middle) **Examination Date**

____ ______________________
Print Physician Name **New Jersey License Number**

□ **I certify that the above named patient is permanently / temporarily disabled and**
(circle one)

may / may not require accommodation.
(circle one)

<u>Please Check and Complete One of the Following Three Options</u>:

□ **I examined the above-named patient on ________________ and certify that the patient has the following permanent / temporary functional limitation(s)/disabling condition:**
(circle one)

____

Major life activity affected: ____

Suggested accommodations: ____

____

□ **I examined the above-named patient on _________________ and I am unable to make a determination without further examination. The patient is scheduled for a follow-up examination on _____________________ with _______________________________________**

□ **I examined the above-named patient on __________________ and I have not found any limitations at this time. This patient may return to regular attendance without restrictions on ____**

Physician Comment: ____

____

____

____

____
Physician Street Address Suite #, City State Zip code

______________________________ ______________________________________
Phone number **Medical Specialty**

______________________________________ ______________________________________
Physician Signature **Date**

<u>Attach any relevant documentation, reports or additional information which you believe may be pertinent to the accommodation review process.</u>