

MEDICAL CERTIFICATION AND SPECIALIST RECOMMENDATION OF REASONABLE ACCOMMODATIONS

I, _____, a licensed health care professional in the specialty of _____, authorized to practice in _____, certify that I evaluated the student, _____.

The student presents the following type of condition (check all that apply):

- ☐ Physical, sensory, neurological, or chronic health condition
- ☐ Mental health condition (e.g., anxiety, depression, bipolar disorder)
- ☐ Neurodevelopmental or learning-related condition (e.g., ADHD, Specific Learning Disorder)

Documentation for Neurodevelopmental or Learning-Related Conditions

Please provide, as applicable:

- When available and clinically appropriate, documentation may include neuropsychological, psychoeducational, psychiatric, psychological, or other evaluations that support the identification of functional limitations and accommodation needs.

Documentation for Mental Health Conditions

Please provide, as applicable:

- Clinical evaluations, standardized symptom rating scales, treatment records, or other documentation that supports the diagnosis and identifies functional limitations relevant to academic participation.
- Documentation supporting the diagnosis based on current DSM-5 criteria, when applicable.

Note: A detailed narrative report is not required. However, sufficient documentation must be provided to support the diagnosis, functional limitations, and accommodation recommendations.

I. Diagnosis:

Based on my evaluation, review of relevant diagnostic information, and treatment of the student, I certify the following diagnosed condition(s) and associated functional limitations.

II. Functional limitations related to academic participation:

III. History:

Date of diagnosis (month/day/year): _____

The condition is: _____ permanent or _____ temporary. If temporary:

Anticipated duration or expected recovery date: _____

Frequency of appointments with the student: _____ weekly _____ monthly _____ 3-6 months _____ annual

Student has received services at our office since (month/day/year): _____

Date of last time the student attended: _____

IV. Current treatment and any functional impacts or side effects relevant to academic participation:

V. Recommendations for reasonable accommodations and supporting rationale:

I certify that the information provided is accurate to the best of my professional knowledge and supports my opinion regarding the student's functional limitations and accommodation needs.

Date: _____

Health Professional Signature: _____

License Number: _____ Specialty: _____

NPI: _____ Phone: _____

Email Address: _____

Office/Practice Name: _____

Authorization for Release of Information in Compliance with the HIPAA Privacy Rule
(To be completed by the student)

I, _____ with student identification number _____,
authorize the release of the requested information to the University of Puerto Rico, Medical Sciences
Campus.

Student Signature

Date