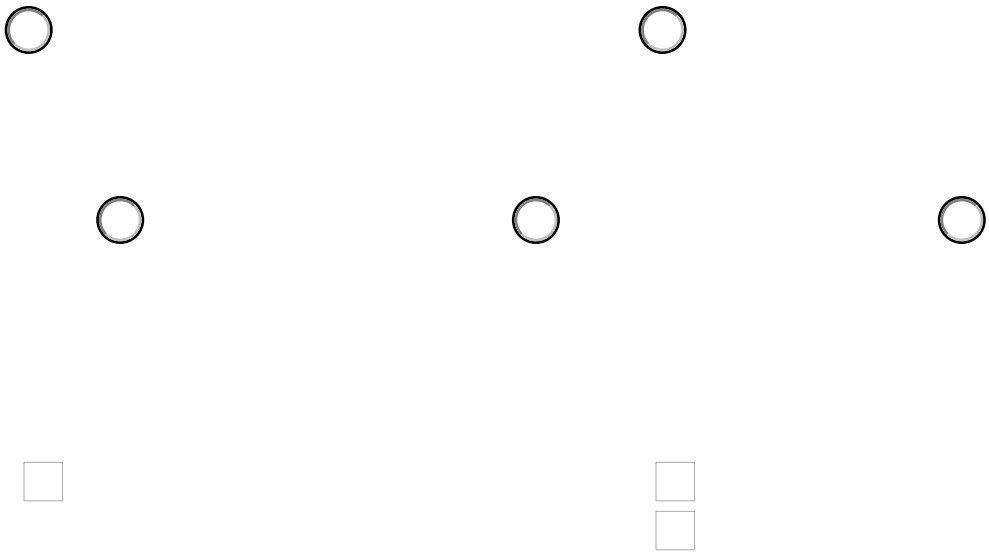

FUNCTIONAL LIMITATIONS

(To be completed by the practitioner - Please check all that apply)

Please check the following activities which are significantly limited by the above stated disability(ies) and/or side effects of medication. Indicate the level of severity as mild, moderate or severe for the identified disability(ies).

1 = Mild 2 = Moderate 3 = Severe

Psychological:

Affect	Coping with Stress	Awareness

Communication:

Receptive Language	Expressive Language	Interacting with Others

Sensory:

Hearing	Visual

Other:

Breathing	Alertness
Stamina	

Learning:

Attention	Writing
Concentration Information	Reading
Processing Memory	Math Reasoning

Mobility:

Ambulation	Range of Motion	Lifting	Reaching
Coordination	Balance	Standing	
Fine Motor	Sitting	Stooping	

MEDICATIONS

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ADDITIONAL COMMENTS

(Attach additional documentation if needed)

Name of Certifying Professional:

License Number: Position Title:

Organization:

Address: State:

City: Zip Code:

IMPORTANT NOTICE

Once the practitioner has signed the form, the form fields in part 2 will be locked and can not be edited. Please make sure the information provided is correct before signing.

Professional's Signature Date

Please submit completed form to:

Bob Murphy Access Center
California State University Long Beach
SSSC-110
1250 Bellflower Boulevard
Long Beach CA 90840

OR

via email at
bmac@csulb.edu

OR

via fax at
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