Disability Medical Assessment Form

Personal Information

- **Full Name: _____**
- **Date of Birth: _____**
- **Contact Number: _____**
- **Address: _____**

Disability Information

- **Nature of Disability: _____**
- **Duration of Disability: _____**
- **Is the Disability Permanent? [ ] Yes [ ] No**

Functional Impact

- **Mobility Limitations:**

  _____
- **Cognitive Impairments:**

  _____
- **Daily Living Challenges:**

  _____

Assistive Devices Used

- **Devices: [ ] Wheelchair [ ] Walker [ ] Prosthetic [ ] Other:**

  _____

Current Medical Support

- **Medications: _____**
- **Therapies: _____**
- **Frequency of Medical Visits: _____**

Assessment Results

- **Does Disability Limit Employment? [ ] Yes [ ] No**
- **Can Accommodations Improve Functionality? [ ] Yes [ ] No**
    - **If Yes, Specify: _____**

Physician Certification

I certify that the information provided in this assessment is accurate and based on a thorough evaluation.

- **Physician's Name: _____**
- **Signature: _____**
- **Date: _____**