Nurse Faculty Program
DISABILITY CHECKLIST

NAME: _____ AGE: _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE:
HOME (_____) _____ WORK (_____) _____ CELL (_____) _____

EMAIL ADDRESS _____

DATE OF BIRTH: _____ CONSENT FOR RELEASE OF INFORMATION (Y/N): _____

DATE ENTERED SCHOOL: _____ DATE TERMINATED: _____

TOTAL AMOUNT OF LOANS OBTAINED (Including interest): _____

NUMBER OF CANCELLATIONS: _____ AMOUNT OF UNPAID BALANCE: _____

EMPLOYMENT PRIOR TO DISABILITY: _____

_____

DIAGNOSIS: _____

_____

DATE AND NATURE OF ONSET: _____

_____

MEDICAL EXAMINATION, TREATMENTS, HISTORY OF ILLNESS, HOSPITALIZATIONS, INPATIENT AND OUTPATIENT TREATMENTS, MEDICATIONS (Include copies of all pertinent past medical records in addition to documentation of a CURRENT medical evaluation):

_____

_____

_____

CURRENT MEDICATIONS: _____

PROGNOSIS: _____

REHABILITATION PLANS: _____

_____

IS ANY TYPE OF GAINFUL EMPLOYMENT POSSIBLE? _____

NOTES: