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):

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____

CURRENT MEDICATIONS: ____

PROGNOSIS: ____

REHABILITATION PLANS: ____

____

IS ANY TYPE OF GAINFUL EMPLOYMENT POSSIBLE? ______________________________________

NOTES: