

CHANGE IN ABILITY TO MEET THE TECHNICAL STANDARDS DURING THE ACADEMIC YEAR

Student Name: _____

Only complete the section below if you have a change in your ability to meet the Technical Standards at any time after you initially attest to meeting the Technical Standards.

“My ability to meet the Technical Standards has changed. My provider has specified the following limitations:”

Please have your healthcare provider complete the following information prior to your return to the clinical environment.

Please check:

_____ Able to fully participate in Nursing Program activities, including clinical, where lifting, walking, standing for extended periods, stooping, kneeling, and communicating (verbal and written) are required.

_____ Able to participate in Nursing Program activities with the following limitations (please be specific):

Duration of the above limitations: _____

Healthcare Provider's Name (please print):

Healthcare Provider's Signature:

Healthcare Provider's Phone Number: (____) _____

Healthcare Provider's Address:

Student Signature/Date: _____