

**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: