Medical Certification of Disability

Medical Certification of Disability Under 34 CFR 300.8
Education Freedom Account Program

Children's Scholarship Fund, 180 Loudon Rd, Concord, NH 03301

Note: Only medical professionals licensed to practice in any state in the United States are authorized to certify this form. While staff of the medical practice associated with the medical professional certifying the form may assist in its completion, the medical professional is responsible for the accuracy of the form's content. Failure to fully and accurately complete this form, including all applicable signatures, may result in the form being found insufficient.

Part 1: Applicant Information

I certify that I have examined the following applicant /child.

Student/Child Name _____
(Last Name) (First Name) (Middle Name, *if any*)

Child Date of Birth _____
(Month) (Day) (Year)

Parent Name _____
(Last Name) (First Name) (Middle Name, *if any*)

Parent/Child Address _____
(Address)

_____
(City) (State) (Zip Code)

Part 2: Medical Professional Information

Medical Professional Name _____
(Last Name) (First Name)

Name of Clinic/Hospital _____

Medical Professional Business Address _____
(Address)

_____
(City) (State) (Zip Code)

License Number _____ Telephone Number _____

Date and location you first examined the applicant regarding the condition(s) listed in Part 3

Date _____/_____/_____ Location _____

Part 3: Information about Applicant /Child Disability

Check one (1) Primary:

___ Autism
___ Deaf-blindness
___ Deafness
___ Developmental Delay
___ Emotional Disturbance
___ Hearing Impairments
___ Intellectual Disability
___ Multiple Disabilities
___ Orthopedic Impairment
___ Other Health Impairments
___ Specific Learning Disability
___ Speech-Language Impairments
___ Traumatic Brain Injury
___ Visual Impairments

Optional, check one (1) secondary:

___ Autism
___ Deaf-blindness
___ Deafness
___ Developmental Delay
___ Emotional Disturbance
___ Hearing Impairments
___ Intellectual Disability
___ Multiple Disabilities
___ Orthopedic Impairment
___ Other Health Impairments
___ Specific Learning Disability
___ Speech-Language Impairments
___ Traumatic Brain Injury
___ Visual Impairments

All medical professionals must attest to the certification below. Failure to do so will result in the form being deemed invalid.

I certify, under penalty of perjury under the laws of the United States of America, that the information on this form is true and correct.

Licensed Medical Professional Signature _____

Date of Signature _____/_____/_____