Medical Certification of Disability
NH Education Freedom Account Program

Note: Only medical professionals licensed to practice in any state in the United States are authorized to certify this form. 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 and even if qualified may not be the students' parent. Failure to fully and accurately complete this form, including all applicable signatures, may result in the form being found insufficient.

Part 1: Applicant Information (To be filled out by the parent/guardian)

Student/ Child Name

_____ **Child Date of Birth**_____/____/_____
(First Name) (Last Name) Middle Name (if any) (Month) (Day) (Year)

Parent / Child Address

_____
(Address)

_____ NH _____
(City) (State) (Zip Code)

Part 2: Medical Professional Information
(To be filled out by a licensed medical professional)

Medical Professional Name

_____
Medical Professional License Number

_____
Name of Clinic/Hospital

_____
Medical Professional Business Address

_____
(Address)

_____
(City) (State) (Zip Code)

Telephone Number

_(___)_____

Part 3: Information about Applicant / Child Disability
(To be filled out by a licensed medical professional)

Date you examined the Student

_____/____/_____
Month) (Day) (Year)

Check all that apply:
___ 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

Part 4: Medical professional completing the form must sign the certification below

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

_____ _____