Shiawassee
Regional Education Service District

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TRAUMATIC BRAIN INJURY CERTIFICATION

TO:
DATE:
FROM / RETURN TO:

This certification form must be completed in order for a student to receive Special Education Services. Please complete the bottom of the form indicating your position.

Guidelines: "Traumatic brain injury" defined; determination. R 340.1716 Rule 16.

(1) "Traumatic brain injury" means an acquired injury to the brain which is caused by an external physical force and which results in total or partial functional disability or psychosocial impairment, or both, that *adversely affects a student's educational performance*. The term applies to open or closed head injuries resulting in impairment in 1 or more of the following areas: See table below.
(2) The term *does not apply* to brain injuries that are congenital or degenerative or to brain injuries induced by birth trauma.
(3) A determination of disability shall be based upon a full and individual evaluation by a multidisciplinary evaluation team, which shall include an assessment from a family physician or any other approved physician as defined in 1978 PA 368, MCL 333.1101 et seq.

CERTIFICATION

Student:	**DOB:**
Parent/Guardian:	

A medical examination has been completed on the above named student. The results indicate traumatic brain injury which will adversely affect educational performance. It is my opinion that the above named student would be eligible for special education services under: 1978 Public Act 368, Michigan Compiled Law, 333.1101 et seq.

☐ I **do not support** this student's eligibility for special education as a student with traumatic brain injury.
☐ I **do support** this student's eligibility for special education as a student with traumatic brain injury.
Please attach report.
Please check the areas of impairment that have occurred as a result of the diagnosed TBI.

☐	Cognition	☐	Behavior
☐	Language	☐	Physical Function
☐	Memory	☐	Information processing
☐	Attention	☐	Speech
☐	Reasoning	☐	Other:

Physician's signature: ____________________________________ Date: ______________________________

☐Orthopedic Surgeon ☐Internist ☐Neurologist ☐Pediatrician ☐Family physician ☐Psychiatrist
☐Other: ______________________________