Disability Verification Form

FOR THE TREATING HEALTH CARE PROVIDER: You have been asked by your patient/client to complete this verification form providing documentation of a disability defined by Section 504 of the Rehabilitation Act and The Americans with Disabilities Act of 1990, as amended.

To determine eligibility for ADA accommodations associated with a physical or mental impairment, Access Services requires current documentation from a licensed treating professional or health care provider who is familiar with the student and their functional limitations based on a diagnosed disability.

Please complete this form in its entirety and attach any additional information needed. Verification forms returned partially complete could result in a delay or denial of accommodations. To accurately complete this form, you must:

- Have knowledge of the student's current level of functioning and any potential access barriers this may present in the academic or clinical environment.
- Complete the following verification form with current knowledge of the student.
- Return the completed form to: access.services@baptistu.edu

Student Name: Last:_____ First:_____

Student ID#:_____ D.O.B.:_____

PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE SO THAT DECISIONS REGARDING STUDENT'S DISABILITY-RELATED ACCOMMODATIONS ARE WELL INFORMED.

Formal Student Diagnosis (including date of diagnosis, DSM-5/ICD-10 codes):

Diagnosis 1: _____ Code: _____ Date Diagnosed: _____

Diagnosis 2: _____ Code: _____ Date Diagnosed: _____

Diagnosis 3: _____ Code: _____ Date Diagnosed: _____

Additional diagnosis and date diagnosed: _____

Date student first visited you for this condition(s): _____

Date student was most recently seen for this condition(s):_____

Expected Duration of Student Diagnosis: ☐ Permanent/Chronic ☐ Temporary ☐ Episodic/Reoccurring

Method used to obtain diagnosis & current symptoms that determine diagnosis:

Provide a detailed explanation of how the disability impacts the student's ability to function in the academic environment, including labs and clinic. **Note***: Simply saying, "John has x and needs extended time" is not sufficient*.

Severity of condition (please choose): ☐ Mild ☐ Moderate ☐ Severe

Current medications, dosage frequencies and potential adverse side effects of these:

Current therapies and other treatments, frequencies of these and any anticipated hospital stays:

Substantial Impact to Major Life Activities:

Definition: The student's activities are significantly restricted when compared to the average individual in the general population when the conditions, manner or duration under which these activities can be performed are considered.

Please check all functional limitations that apply, including information on how each will impact your patient/client within the academic or clinical environment:

Functional Limitation	Mild	Moderate	Substantial	How is the life activity impacted by the diagnosis?
Caring for Oneself				
Performing Manual Tasks				
Seeing				
Hearing				
Breathing				
Sleeping				
Eating				
Standing				
Lifting				
Bending				
Walking				
Speaking				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Memory				
Working				
Operation of a major bodily function				
Other:				
Other:				

Suggested Reasonable Accommodations:

Based on the functional limitations described, what accommodation(s) is essential to ensure that the student has the same opportunities as non-disabled peers? Each proposed suggestion should include a rationale that is supported by a diagnosis previously documented on this form.

Please note: recommended accommodations will be considered, but are not automatically included as part of a student's approved accommodations.

Suggested Accommodation	What Makes This Necessary?	Functional Limitation this may Accommodate

Potential consequences should the student not receive the requested accommodation(s):

Additional Information and/or Comments (background/medical/psychosocial information, etc.):

Practitioner Name & Title: _____

Specialty/Qualifications for Determining Diagnosis: _____

State License and/or Certification Number: _____

Practitioner Signature: _____

Date: _____

Address: _____

Email: _____

Phone: _____