



VERIFICATION OF DISABILITY FORM

This form must be completed and signed by your licensed healthcare provider

Purpose: The information you provide will be used to determine the nature and severity of the student’s condition and the appropriateness of requested accommodations or services.

Please take the time to complete this form in its entirety as detailed as possible.

Disability Category and Requested documentation:

- **Chronic Health Conditions** other than those listed below - this form should be completed and signed by an appropriate licensed medical specialist (MD/DO/NP).
- **Psychological Disabilities** other than ADD/ADHD - this form must be dated within one year and completed and signed by a licensed counselor, therapist, psychologist or psychiatrist (mental healthcare professional).
- **ADD/ADHD** - attach a comprehensive Psychological Evaluation dated within 3 years and signed by a licensed psychologist or this form must be dated within one year by treating healthcare provider.
- **Learning Disabilities** - attach a comprehensive Psychological Evaluation Report with subtest scores, dated within 3 years and signed by a licensed psychologist.
- **Hearing Impairment or Deaf** - complete and attach the most recent audiogram dated within one year. Form and Audiogram must be signed by a licensed audiologist.
- **Visual Impairment or Deaf** - attach recent acuity and field of vision dated within 3 years. Form and Vision assessment must be signed by an ophthalmologist.
- **Allergies or Asthma**– If allergies, attach allergy results dated within 3 years. Form and Test results must be signed by an allergist or pulmonologist.

For Any Disability, Additional or More Recent Documentation May Be Required

Student Name: _____

Diagnosis(es): _____

Onset of Condition(s): _____

Date of Last Visit for Condition: _____

Current Status (e.g. Active, Progressing, Controlled, In Remission) _____

GAF score if applicable: _____

Expected Duration of each medical condition (lifetime, one year, one semester, one month):

Functional Limitations:

What are the student's current functional limitations (*again, be as specific and detailed as possible and provide information for all disability areas*): 1) ambulation; 2) upper extremity or fine motor function; 3) hearing; 4) vision; 5) cognitive processes—concentration, rapidity of information processing, memory, fatigability, others:

Severity of Functional Limitations:

In comparison to the average person in the general population, please rate the severity of the student's functional **limitations noted above**, both with and without the use of mitigating measures (interventions), such as medication and treatment:

Without Mitigation (Intervention):

- Mild
- Moderate
- Substantial
- Severe

With Mitigation (Intervention):

- Mild
- Moderate
- Substantial
- Severe

What exacerbates the specific disability this student has? (*again, be as specific and detailed as possible*) _____

Treatment Plan:

Please describe treatment plan including medications related to the condition that the student is currently taking including dosage and frequency. Please include both the positive as well as any negative effects

of the medication (attach a separate sheet if necessary):

Attendance, Participation, Clinical Activities, Student Teaching etc:

Please describe the impact that the student’s condition will have on his/her ability to attend or participate in classes, clinical activities, student teaching etc:

Please describe the impact this student’s condition has on his/her overall ability to learn, or on other cognitive abilities: _____

Living on Campus:

Please describe the impact this student's condition has on his/her overall ability to live in campus housing:

Recommended Accommodations:

Identify any accommodations you believe may be **necessary** in order for the student to participate in the University’s programs, activities and services:

Anticipated duration of need for accommodation: _____

Name of Treating Healthcare Professional: _____

Specialty: _____

License # and State: _____

Address: _____

Telephone: _____

Signature (**verifying that you are not related to the student by blood or marriage**):

Date: _____

Contact Access and Accommodation at (478) 301-2810 with any questions. All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). Thank you for your assistance. This form is available on-line at www.access.mercer.edu

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