VERIFICATION OF PHYSICAL /SENSORY DISABILITY OR MEDICAL CONDITION

To Be Completed By Appropriate Treating Clinician

Date _____

I, the undersigned, certify that:

Name of student: _____

Date of Birth: _____

Address:_____

_____

Phone: ( )_____

Has the following diagnoses/condition:

1.) Diagnosis/description of medical condition. **INCLUDE ICD-9 or DSM-IV CODE:**

2.) Symptoms/functional limitations (e.g., limited ambulation; poor visual acuity, degree of hearing loss):

3.) This individual's condition substantially limits him or her in a major life activity:

(circle one) Yes No

If yes, what activities are significantly limited?

_____

_____

4.) Current treatment(s)/therapy and prescribed medications and dosage:

5.) The medical condition or disability above is:

- ☐ Permanent/chronic
- ☐ Long term: 6-12 months
- ☐ Short term/temporary: 6 months or less

  Expected duration: _____

6.) The condition or disability is:

- ☐ Observable
- ☐ Not observable

7.) Please use space below (and additional paper, if necessary) to provide any information that will be helpful to Disability Services staff in considering the accommodations that you are recommending.
   a.) Is impact of the condition life threating if the request is not met?
   b.) Is there a negative health impact if request is not met?
   c.) What is the likely impact on academic performance if the request is not met?
   d.) What is the likely impact on social development if the request is not met?
   e.) What is the likely impact on level of comfort if the request is not met?
   f.) Is the request an integral component of a treatment plan for condition on question?

_____

_____

_____

_____

8.) Please list any academic, housing, or other accommodations you recommend:

_____

_____

_____

All recommendations are considered. Decisions are made based on the nature of the disability, reasonableness of the request, academic integrity, and available housing.

Signature Date

Name (Please Print)

Title

Name of Agency/Practice

( ) ( )

Phone Number Fax Number

Street Address

City/State/Zip

All documentation submitted for consideration to the Services for Students with Disabilities Office is confidential. When submitting documentation, **please include a copy of any available releases** allowing communication between Disability Services Counselor and the diagnostician. Documentation can be mailed to:

Jefferson College of Health Sciences
Attn: Disability Services Counselor
101Elm Ave., SE.
Roanoke, VA 24013
Fax: (540) 985-8001
Please include a fax cover sheet for confidentially purposes