# Disability Verification Form for Medical Providers

**Purpose:** The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Kean University. The information you provide will be one of the criteria used to evaluate the student’s eligibility for the requested accommodations or services. Please complete this form in its entirety. All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

## Student Information:

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| Student’s First Name: |  |
| Student’s Last Name: |  |

The remainder of this document must be completed by a certified/licensed Health Care Provider. Completion of the verification form is not adequate. Your medical provider MUST attach copies of evaluation and diagnostic evaluation reports for EACH area of disability.

Date of First Diagnosis: Click or tap to enter a date.

Date Student was first seen: Click or tap to enter a date.

Date Student was last seen: Click or tap to enter a date.

How long have you been treating the student?

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## **Medical Condition Information:**

Diagnosis and description of the student’s medical condition:

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Frequency of appointments:

Once a week

Twice a week

Once a month

Once every six months

Once a year

As-needed

What is the severity of the condition?

Mild

Moderate

Severe

Explain the severity selected above:

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What is the expected duration of the condition?

Short-term (less than six months)

Episodic

Long-term (6 months to one year)

Chronic (longer than one year with frequent recurrence)

Is the student able to ambulate?  Yes  No

Can the student negotiate stairs, or is an elevator required? Please explain.

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## **Symptoms and Accommodations**

Please list the student’s current symptoms. Then, indicate what reasonable academic accommodations would be related to the symptom indicated. (More detailed information regarding reasonable academic accommodations can be found at: reasonable accommodations).

**Example:** Symptom: “Due to the student’s Crohn's Disorder, the student has frequent stomach pain and is required to use the restroom numerous times throughout the day. Often this is an emergency type of frequency and may affect attendance.”

**Recommended Reasonable Accommodation:** “Student will require frequent breaks, consideration of attendance policies, and possibly breaks during quizzes or exams as necessary without penalty."

**Symptom 1**

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**Recommended Reasonable Accommodation**

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**Symptom 2**

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**Recommended Reasonable Accommodation**

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**Symptom 3**

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**Recommended Reasonable Accommodation**

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**Symptom 4**

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**Recommended Reasonable Accommodation**

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**Symptom 5**

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**Recommended Reasonable Accommodation**

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## **Medication**

Is the student currently taking any medication?  Yes  No

If yes, please provide information on each medication below:

(e.g., Celebrex, 200 mg, 1x daily, 1/1/2020, Dr. John Doe)

**Medication 1, Dosage, & Frequency**

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| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
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| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
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**Medication 2, Dosage, & Frequency**

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| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
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| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
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**Medication 3, Dosage, & Frequency**

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| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
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| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
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**Medication 4, Dosage, & Frequency**

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| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
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| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
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**Additional Medication Comments:**

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Note: Please attach any supporting documentation that you feel can assist our office in the determination of reasonable accommodations.

## **Health Care Provider Completing this form:**

Role of the individual completing this form (check all that apply).

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| Medical Doctor | | Evaluator |
| Psychotherapist | | Second Opinion Evaluator |
| Medication Supervisor | |  |
| Other: |  | |

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| Provider Full Name: |  |
| License Number: |  |
| Title/Profession: |  |
| Street Address: |  |
| City, State, Zip |  |
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| Phone Number: |  |
| Fax Number: |  |
| E-mail Address: |  |

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| Provider Signature: |  |

Today’s Date: Click or tap to enter a date.

**Please contact us with any questions at (908) 737-4910 or** [**accessibilityservices@kean.edu**](mailto:accessibilityservices@kean.edu)

**Please return this form to:** [**accessibilityservices@kean.edu**](mailto:accessibilityservices@kean.edu) **or**

**Office of Accessibility Services**

**Downs Hall Room 122**

**Kean University**

**1000 Morris Avenue,**

**Union, NJ 07083**