Verification of Physical/Health-Related Disabilities

Baker University – Office of Disability Resources

To determine your eligibility to receive accommodations and support services, the Office of Disability Resources requires specific information from you and your health-care provider. You must sign the release of information below giving Disability Resource staff permission to speak with your provider to answer questions related to your documentation. You must complete page 1, and your provider must complete pages 2-4. The entire verification form should be returned to the address listed on page 4.

Student Completes This Section (Please Print or Type)

Student name:

_____

(Last) (First) (Middle)

Student I.D. number:

_____

Birth date: _____ Gender: ❑ Male ❑ Female

Are you currently enrolled at Baker University? _____ Current semester standing: _____

Home address: _____

Home phone #: _____

Local address: _____

Local phone #: _____ E-mail address: _____

Authorization to Receive Information

I authorize the Office of Disability Resources to *receive* information *from* the provider below. I also authorize my provider to discuss my condition(s) with the Office of Disability Resources.

Name of provider: _____

Address (Street, City, State, and ZIP code):

_____

_____

Student's signature: _____ Date: _____

Verification of Physical/Health-Related Disabilities

Student's Name:

_____

Social Security number: _____

Provider Completes the Section Below

Baker University provides accommodations and support services to students with diagnosed disabilities. A student's documentation regarding his or her condition must demonstrate that he or she has a disability covered under the Americans with Disabilities Act (ADA, 1990). **The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.** To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the student's disorder from the diagnosing physician or health-care provider. **The provider completing this form *cannot* be a relative of the student. Items 1-7 must be completed in full.** If the space provided is not adequate, please attach a separate sheet of paper. The provider should attach any reports that provide additional related information (e.g., psycho-educational report and test scores, psychological test results, etc.).

Please respond by typing the following items regarding the student named above. *Illegible forms may delay the process for the student.*

1. What is the student's medical condition/diagnosis?

_____

_____

_____

a) How long has the student had this condition?

_____

_____

b) What is the severity of the condition? Please check one: ❑ Mild ❑ Moderate ❑ Severe
Please explain severity:

_____

_____

c) What is the expected duration of this condition? Is it chronic, episodic or short-term? (Please explain.)

_____

_____

2. Please state the following:
   a) Date of first contact with student:

   _____

   b) Date of last contact with student:

   _____

   c) Frequency of appointments with student:

   _____

3. Describe the differential diagnoses that were excluded. State your reasons for considering these diagnoses and your reasons for ruling them out.

   _____

   _____

   _____

4. Explain how the symptoms related to the student's condition cause significant impairment in a major life activity (e.g., in a classroom setting).

   _____

   _____

   _____

   _____

5. List this student's current medication(s), dosage, frequency, and adverse side effects (if applicable for the above-mentioned diagnosis).

   _____

   _____

   _____

   _____

   a) Do the prescribed medications directly limit the student's ability to function?
      ❑ Yes ❑ No

   b) If yes, please explain:

      _____

      _____

      _____

6. Please state specific recommendations regarding accommodations for this student and a rationale for why these accommodations are warranted based on the student's functional limitations. Indicate why the accommodations you recommend are necessary (e.g., if you suggest a notetaker, state the reasons for this request related to the student's condition).

_____

_____

_____

_____

7. If current treatments (e.g., medications) are successful, why are the above accommodations necessary?

_____

_____

_____

_____

The provider may also send a report that provides additional related information.

The provider completing this form cannot be a relative of the student.

_____

Signature of provider Date

License # _____ State _____

(Please Type)

Name/Title: _____

Address: _____

Phone: _____

Please Return completed form to:

Baker University
Director of Student Services
8001 College Blvd., Suite 100
Overland Park, KS 66210
Phone: 913-491-4432
Fax: 913-491-0470