

# Physician or Specialist's Verification of Disability



SIMMONS UNIVERSITY  
ACCESSIBILITY SERVICES  
Center for Student Success  
300 The Fenway, Boston, MA 02115  
p. 617.521.2474

Student Name: \_\_\_\_\_

SIMMONS ID# \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_\_\_

*Reminder: A copy of the most recent psycho-educational or disability-related evaluation is required to fully register with OAS. When primary documentation can be supplied, this document serves as a supplement to complete the file.*

The Office of Accessibility Services at Simmons College requires that students with disabilities who request accommodations provide documentation from a licensed health professional (physician, psychiatrist, or other medical specialist). Documentation must support the need for accommodations as related to the status of the student's disabling condition.

Scan to [access@simmons.edu](mailto:access@simmons.edu) or U.S mail completed form to the address listed above.

*Please have your licensed health professional complete the following information.*

## DIAGNOSIS INFORMATION

Diagnosis in the area(s) of:  ADHD  Psychiatric  Learning  Medical

Primary Diagnosis(es) and results of evaluation (medical / DSM-IV or -V): \_\_\_\_\_

Date of establishment / Age of onset \_\_\_/\_\_\_/\_\_\_\_\_ Diagnosed by (provider's name) \_\_\_\_\_

Initial evaluation method(s): \_\_\_\_\_

Date of most recent evaluation \_\_\_/\_\_\_/\_\_\_\_\_ Evaluation type:  Psycho-educational  Disability-related

Evaluation method(s): \_\_\_\_\_

Schedule for re-evaluation: \_\_\_\_\_

## BACKGROUND HISTORY

*Please discuss any pertinent background information related to the diagnosis.*

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## EVALUATION PROCEDURES

Please list assessment or evaluation procedures, results, and any additional information related to the evaluation of the student's disability. (e.g. specific testing, weekly therapy, check-in appointments)

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## CURRENT IMPACT OF DIAGNOSIS

Please describe the student's condition. We ask that you include how the condition impacts the student and the student's educational history, level of impairment, progress and/or treatment as applicable.

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Severity of symptoms:  Mild  Moderate  Severe

## IMPACT ON MAJOR LIFE ACTIVITY IN ACADEMIC SETTING

Does the diagnosis constitute a *current and substantial* limitation on a major life activity (i.e. learning)?

YES  NO

Please describe the limitations on learning and the degree to which the student's disability impacts academic performance and the student's ability to meet the demands of the academic program.

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**CURRENT MEDICATIONS AND TREATMENT**

*Please list any prescribed medications, their dosages, and any adverse side effects, if applicable.*

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Condition is:  Stable  Prone to exacerbation  Permanent/chronic  Temporary

**RECOMMENDATIONS / ADDITIONAL COMMENTS**

*Please provide a list of recommended accommodations and how they will address the student's specific needs for a fair and equal opportunity to learn relative to same-aged college peers. Specific accommodations will be determined and approved by the Office of Accessibility Services.*

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**EVALUATOR QUALIFICATIONS**

*I understand that the information provided will become part of the student record and may be released to the student upon the student's written request.*

Printed Name of Verifying Evaluator \_\_\_\_\_ Signature \_\_\_\_\_

Title \_\_\_\_\_ License Number \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Fax \_\_\_\_\_

**Send completed form to:**

Office of Accessibility Services  
Simmons University  
Center for Student Success  
300 The Fenway  
Boston, MA 02115

This form may also be scanned to [access@simmons.edu](mailto:access@simmons.edu)