Treating Practitioner’s Verification of Disability/Illness Related to Request for Accessible Housing Accommodations

Documentation must be provided by a licensed or credentialed professional with specific training or expertise related to the condition being diagnosed (e.g. anxiety disorder diagnosed by a licensed psychiatrist, psychologist, social worker, or clinical nurse practitioner). The following questions address the required criteria for eligibility. This request form must be fully legible for processing.

Student Name: ____________________________  Today’s Date: ___________________

Student ID #:_____________________________  Class rank (FR, SO, JR, SR): __________

Diagnosis in the area(s) of [circle all that apply]:  Psychiatric  Physical  Medical  Learning

Date last seen by your office relative to the disability in question: ___________________________

When the disability was first diagnosed: ____________________________ By whom: ___________________

Evaluation method(s) used: ______________________________________________________________

Severity of current symptoms (circle one):  Mild  Moderate  Severe

Condition is (circle one):  Stable  Prone to exacerbation  Permanent/chronic  Temporary

1. Diagnostic statement: identify the disability, and the diagnostic codes of the condition (e.g. DSM-V or ICD-10). ____________________________________________________________

2. Describe the diagnostic methodology that led to that diagnosis (e.g. testing, clinical narrative, observations, etc.). ____________________________________________________________

3. Describe the current functional limitations due to the disabling condition, demonstrating how a major life activity is significantly limited by the frequency and pervasiveness of the condition. __________

_________________________________________________________________________________

_________________________________________________________________________________

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_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________
4. What is the expected prognosis or stability of the disability? ________________________________

5. Describe all **current** and **past** interventions including medications, including evidence of a documented assessment and/or a treatment plan as well as the subsequent progress notes summarizing the effectiveness of the various interventions. ______________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________
   _____________________________________________________________________________

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

_______________________________________________  _____________________________
PRINT Name of Verifying Professional  PRINT Title

_______________________________________________
Verifying Professional’s Signature  Date

Address: __________________________________________

Phone # ____________________

City, State, Zip Code: __________________________________________

________________________________________________________________________

Office of Accessibility Services
Center for Student Success | Simmons University
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Boston, MA 02115
617-521-2658

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Please send your email inquiry: access@simmons.edu