Physician or Specialist's Verification of Disability

SIMMONS UNIVERSITY
ACCESSIBILITY SERVICES
Center for Student Success
300 The Fenway, Boston, MA 02115
p. 617.521.2658

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 University 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.

Submit this verification form through our secure file transfer link, found at https://filetransfer.simmons.edu/form/OAS, or by U.S mail 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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_____

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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 submitted digitally through our secure file transfer link:
https://filetransfer.simmons.edu/form/OAS