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 disabiling 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.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
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)

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.

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.
CURRENT MEDICATIONS AND TREATMENT

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

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

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.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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

Version: June 2019