Practitioner’s Verification of Diagnosis For Housing Accommodations – Academic Year 2020-2021

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) for review of accommodation eligibility. This request form must be fully legible in order to be processed.

Student Name: ___________________________  Today’s Date: ______________________

Student ID #: __________________________________________

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

Date last seen by your office relating to the diagnosis in question: ___________________________

Date of initial diagnosis: ________________  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 diagnosis and the diagnostic codes of the condition (e.g. DSM-V).

________________________________________________________________________________________

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

________________________________________________________________________________________

3. Describe in detail the current functional limitations for this student 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 diagnosis? __________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

5. Describe all current and past interventions—including medications, evidence of a documented
   assessment, and/or a treatment plan—as well as the subsequent effectiveness of these interventions for
   treating the symptoms of the diagnosis. ______________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

6. Provide a list of recommended accommodations and describe how they will address the student’s
   specific housing needs and access relative to the diagnosis. ______________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

I understand that the information provided will become part of the student’s record with the Office of
Accessibility Services 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: ______________________________

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Office of Accessibility Services
Center for Student Success | Simmons University
300 The Fenway
Boston, MA 02115
617-521-2658
This form may also be submitted digitally through our secure file transfer link:
https://filetransfer.simmons.edu/form/OAS
Please send your email inquiry: access@simmons.edu

Version: February 2020