



## PHYSICAL/MEDICAL DISABILITY VERIFICATION FORM

**To be completed by a licensed health care provider who is an impartial evaluator and not a family member or in a dual relationship with the student.**

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

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date student was first seen: \_\_\_\_\_ Date student was last seen: \_\_\_\_\_

How often do you see this student? \_\_\_\_\_

Provider Name: (Printed) \_\_\_\_\_

Credentials and State License #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

*Affix card here or office stamp (optional)*

## SECTION 1: VERIFICATION OF DISABILITY

The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits a major life activity. Please note that a diagnosis alone does not automatically qualify a student for accommodations. The information on this form should identify a disability, describe its current impact and address how the impairment substantially limits a major life activity.

1. Is the student's condition, as they currently experience it, classified as a disability?  No  Yes (If no, there is no need to continue further with this form)
2. Diagnosis(es) \_\_\_\_\_  
\_\_\_\_\_
3. Current Severity \_\_\_\_\_
4. Current Prognosis \_\_\_\_\_
5. What are the student's current symptoms and how do they substantially limit at least one major life activity? (Note: major life activity is inclusive of learning, reading, concentrating, and thinking)

## SECTION 2: DURATION OF ASSOCIATED FUNCTIONAL LIMITATIONS (please check)

- Permanent, continuous: Ongoing functional limitations that will impact the student over the course of their academic career and are unlikely to change
- Permanent, episodic: Periods of good health interrupted by periods of illness or disability over the course of their academic career. If yes, please provide specific description of occurrences per day/week/month and length of impact: \_\_\_\_\_
- Temporary: These functional limitations are temporary, or the severity may change, and should be reassessed in future. Student to be reassessed by: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Provisional: I am still monitoring/assessing the student. Assessment likely to be completed by: \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 3: ASSESSMENT METHODS OVERVIEW (check all that apply)

- Medical Tests (w/dates): \_\_\_\_\_  
\_\_\_\_\_
- Student self-report: \_\_\_\_\_
- Pharmacological history: \_\_\_\_\_
- Relevant Medical History \_\_\_\_\_  
\_\_\_\_\_
- Other: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 4: CURRENT TREATMENT

1. Please list ongoing or upcoming treatment modalities (such as PT, OT, follow-up, specialist referrals)

2. Has the student recently been hospitalized for treatment of this diagnosis/disability?  Yes  No

If yes, please indicate the most recent date range of hospitalization:

\_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

3. List medications the student is currently taking:

*Medication:*

*Side effects experienced by student:*

4. Relevant additional information that has impacted the student within the last 12 months (such as compliance, persistence of symptoms, or significant life events)

5. Please list any coexisting conditions that should be considered when determining accommodations. Provide diagnosis, dates of prior testing and name of evaluator.

## SECTION 5: ACADEMIC ACCOMMODATIONS

**Please note:** Accommodations at the college level are intended to provide access rather than ensure success. The ADS office may find that the recommended accommodation is not appropriate and propose a reasonable alternative. Accommodations such as modification to attendance and extended deadlines are rarely considered reasonable at the college level.

What accommodations would you support and why?

Is there anything else you think we should know about the student's disability and their ability to function academically and socially in a college environment?

**Please return to the office by:**

Email: [tuads@towson.edu](mailto:tuads@towson.edu), Fax: 410-704-4247 or Return to student to deliver

