Physical or Medical Disability Verification Form
To be Completed by Disability Provider

You are being asked to provide documentation of a physical disability for your client/patient:
(Name) _____, (DoB) _____

Please complete the form below and attach the appropriate supplemental documentation. Thank you in advance for your support and cooperation in this matter.

Practitioner Name & Title: _____

Address: _____ Date: _____

License or Certification Number: _____

Specialty/Qualification to make diagnosis: _____

Date of last appointment: _____

To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. These laws define a person with a disability as one who 1) has a physical or mental impairment which substantially limits one or more major life activities, or 2) has a record of such impairment, or 3) is regarded as having such an impairment. "Major life activities" are functions such as walking, seeing, hearing, speaking, breathing, thinking, concentrating, communicating, learning, caring for one's self, performing manual tasks, reproduction and working.

1) Nature of disability (formal diagnosis). Please include expected duration:

_____
_____
_____
_____

2) Severity of condition: ☐ Mild ☐ Moderate ☐Severe

3) Check all relevant functional limitations which are substantially limited:

☐walking ☐hearing ☐seeing ☐working ☐sleeping ☐caring for self
☐interacting with others ☐learning/memory/concentration
☐performing manual tasks ☐Other: _____

4) Please explain how each of the above-mentioned functional limitations will specifically affect your client in the academic environment**:**

_____
_____
_____
_____
_____

5) What accommodations, if any, would you recommend as reasonable for client? Each accommodation should be supported by the diagnosis. Please discuss the rationale for each suggested accommodation and relate it to a specific functional limitation**.**

_____
_____
_____
_____

6) Additional comments**:** _____
_____
_____
_____

Please note that the Coordinator of Disability Services (CDS) will make all final decisions on which reasonable accommodations will be granted**.**

X_____
Diagnostic Practitioner

Date:_____

Please return this form and supporting materials to the Disability Services Office

Lyndon Campus:
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802-626-6424

Johnson Campus
Pam Billings
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