UNIVERSITY

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Clarskon University
Office of Accommodative Services
Verification of a Physical, Medical or Sensory Disability

(Do not use for Learning Disabilities, ADD/ADHD, Psychological or other cognitive disorders)

The Office of Accommodative Services at Clarkson University provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. A disability must **substantially limit** one or more major life activity, such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, and working. Current and comprehensive disability documentation from a health-care provider (who is not a relative of the student) is required to assist with the provision of appropriate and reasonable accommodations and/or auxilliary aids. For hearing impairments, include a recent audiology report. For visual impairments, include results of a recent eye exam. Additional documentation may be required.

To be completed by a certified health care professional.

All items are required. Please print legibly. Include additional pages, if needed.

Physician's Name: ______________________ Today's Date: __________

Address: ____

____

License/Cert. #: ______________ Phone: ______________ Fax: ______________

Student's Name: ______________________ Date of Birth: __________

Complete Diagnosis ____

____

Date of Dx: __________ Severity (circle one): Mild Moderate Severe Remission

Procedures/assessments used to diagnose this student's condition: __________

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____

Treatment and/or medications currently being used: ______________________

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____

Functional limitation(s) caused by this condition and/or its treatment: __________

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____

Recommended accommodation and/or auxiliary aids (must be clearly linked to functional limitations):

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Anticipated Duration of Accommodation: ______________________

Physician/Health Care Provider Signature: ______________________

I, ______________________, authorize the above health-care provider to release to the Office of Accommodative Services the medical information requested on this form for the purpose of determining appropriate accommodation for my permanent or temporary disability while a student at Clarkson University.

Signature of patient: ______________________ Date: __________

If signed by person other than patient, state relationship, and authority to do so.

Relationship: ______________ Legal Authority: ______________