Disability/ Medical Condition Verification Form

Dear ___________________________,

Pursuant to the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, Emmanuel College seeks to provide reasonable and appropriate accommodations to any qualified student who has "a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment." To make a determination of whether accommodations are appropriate for such a student, relevant current documentation is required.

You are being asked to provide documentation of a disability for your client. Please fill out the form below (**all sections are required to be completed**) and attach the appropriate documentation, if necessary. Thank you in advance for your support and cooperation in this matter.

Student Name: ____ D.O.B.:____

Semester for which accommodations are being requested: FALL SPRING Year ____

Practitioner Name/Title ____

Address____

Phone Number __________________________________ License or Certification Number_________________________________

Specialty/Qualification to make diagnosis ____________________________ Date of client's last appointment___________________

Please provide a detailed description of how this client's impairment significantly impacts her/his daily functioning in a college environment:

Nature of Disability (Formal Diagnosis). Please include expected duration:

ICD or DSM Diagnosis and Severity of Condition. (Mild, Moderate, Severe, etc.):

Check all relevant functional limitations that are substantially limited. Mitigating measures should not be considered in assessing whether an individual has a disability. An impairment that is episodic or in remission is a disability if it would substantially limit major life activity when active.

____Ambulating ____Hearing ____Vision ____Working ____Speaking ____ Breathing

____Eating ____Sleeping ____ Caring for self ____Communication skills ____Absences

____Learning (including memory/concentration) ____Performing activities of daily living ____Other: ________________________

Specific *symptoms* which meet the criteria for this diagnosis and approximate date of onset:

Current treatment (counseling, prescribed or recommended medication, etc.) and *prognosis:*

Recommended classroom /course accommodations:

Signature of Health Care Provider____ Date: ____________________

The provider cannot be a family member of the student.

Please return this form to:

Alyson Czelusniak, Associate Director, Disability Support Services **OR** Noelle Galli, Accommodations Coordinator, Disability Support Services

Tel: 617-735-9923 | czelusniaka@emmanuel.edu Tel: 617-732-1681 | gallin@emmanuel.edu

Fax: 617-975-9322

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IMPORTANT - AS OF 3/16/20 – ALL FORMS MUST BE SUBMITTED VIA EMAIL AS THE CAMPUS IS WORKING REMOTELY AT THIS TIME.

Revised 4/8/20