Verification of Disability Form: Acquired Brain Injuries/Disabilities

Disability Services at Davenport University strives to ensure that qualified students with acquired brain injuries/disabilities are accommodated to best assure the successful completion of academic requirements and to obtain the benefits of participation in the academic community. Students with disabilities must still satisfy essential academic program requirements, with or without accommodation.

Davenport University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equal access to the University programs and services. Federal law defines a disability as “a physical or mental impairment that substantially limits one or more major life activities.” Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. An acquired brain injury in and of itself does not necessarily constitute an impairment. The degree of impairment must be significant enough to “substantially limit” one or more major life activity.

Students who wish to receive academic adjustments due to an acquired brain injury/disability need to have this form filled out by a qualified healthcare provider. The healthcare provider completing this form must have first hand knowledge of the student’s condition and must have experience diagnosing and treating this condition.

Release of information

I, ____________________________, authorize the exchange and release of information regarding academic adjustments; auxiliary aids and/or accommodations related to my disability with relevant Davenport University academic and operations personnel. I understand that my disability related records including test scores, evaluations and diagnoses will be kept confidential and will be shared only on a need-to-know basis within the institution. I understand this consent will remain in effect as long as I am a current student at Davenport University or until revoked by me by giving written notice to the Disability Services Coordinator at my location.

__________________________   ____________________________
Student’s Signature          Date

Student Information (This section to be completed by the student)

Last Name_____________________________ First _________________________ MI __
Student ID# __________________________ Date of Birth ______________________
Permanent Address __________________________ Phone __________________
City_____________________________ State ____ Zip Code _______________
Certifying Professional

Name ______________________________________________________________

Credentials ______________________________________________________________________________

Address ___________________________________________________________________________________

City_____________________________ State ___________ Zip Code __________________________

Phone _________________________________ Fax _________________________________

License/Certification number and state of licenser ________________________________________________

Date of initial contact with student _____________________________________________________________

Date of last contact with student _______________________________________________________________

Diagnosis:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Date of Diagnosis _______________________________

Basis on which diagnosis was made _____________________________________________________________

__________________________________________________________________________________________

Current medications including dosage and side effects _____________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Long term treatment plan ____________________________________________________________________

__________________________________________________________________________________________

Student’s current compliance with treatment plan _________________________________________________

__________________________________________________________________________________________

Prognosis for treatment plan (Include likelihood of improvement or further deterioration and within what approximate time frame.) _______________________________________________________________________________

__________________________________________________________________________________________
Planned therapeutic interventions

Prognosis for therapeutic interventions (Include likelihood for improvement or further deterioration and within what approximate time frame.)

Student’s current compliance with therapeutic interventions

History of hospitalization

Implications for Educational Success

Learning abilities specific to the post secondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc.)

Implications for taking exams and other classroom activities caused by disability, medication, or treatment.

Please specify which and explain why:
Suggested accommodations. Each recommended accommodation should be accompanied by a detailed explanation of its relevance to the disability that is diagnosed. Please indicate the level of impairment at which the individual is currently functioning even with the benefits of treatment. The final determination of any effective accommodations is left to the University. Please attach a neuropsychological report.

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I certify that the above information is accurate and complete.

__________________________________________________________________________________________
Signature of Healthcare Provider

__________________________________________________________________________________________
Date

This form should be returned to the Disability Service Coordinator at the location the student attends or

Davenport University
Office of Student Services
Attn: Student Access Manager
6191 Kraft Avenue SW
Grand Rapids, MI 49512
Phone (866) 925-3884
Fax (616) 554-5214