Verification of Disability Form:

Student Access at Davenport University strives to ensure that qualified students with _____ 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. 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 _____ 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. Evaluator also should indicate the level of impaired functioning 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 send or attach any additional documentation that may be helpful.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the above information is accurate and complete.

_____ _____

Signature of Healthcare Provider **Date**

This form should be returned to the Student Access Coordinator at the location the student attends or

Davenport University
Office of Campus Life
Attn: Campus Life Coordinator
6191 Kraft Avenue SE
Grand Rapids, MI 49512
Phone: (616) 554-5184
Fax: (616) 871-6730
Email: studentaffairs@davenport.edu