



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

As the certifying professional completing this form, recommendations below should be based on current and historic provider / patient relationship which is ongoing.

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:

Please use DSM diagnostic codes and official diagnosis names

Date(s) of Diagnosis _____

Basis on which diagnosis was made _____

Current medications including 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:

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Signature of Healthcare Provider

Date _____

Davenport University
Campus Life
6191 Kraft Avenue SE
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