Verification of Disability Form: Acquired Brain Injuries/Disabilities

Student Access 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 firsthand 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 Student Access 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 Student Access Coordinator at the location the student attends or

Davenport University
Center for Campus Life
Attn: Executive Director of Campus Life
6191 Kraft Avenue SE
Grand Rapids, MI 49512
Phone: (616) 554-5687
Fax: (616) 871-6730
Email: studentaffairs@davenport.edu