Verification of Disability Form: Chronic Health Conditions

Student Access at Davenport University strives to ensure that qualified students with chronic health conditions 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. A chronic health condition 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 chronic health conditions 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. 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.

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
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Grand Rapids, MI 49512
Phone: (616) 554-5687
Fax: (616) 871-6730
Email: studentaffairs@davenport.edu