Practitioner's Verification of Diagnosis

SIMMONS UNIVERSITY
ACCESSIBILITY SERVICES
Center for Student Success
300 The Fenway, Boston, MA 02115
p. 617.521.2658

Student Name: _____

SIMMONS ID# ___ ___ ___ ___ ___ ___ ___

Today's Date: ___ /___ /_____

This document must be completed by a licensed health professional only.

The Office of Accessibility Services (OAS) at Simmons University requires that students with a diagnosis which significantly impacts a major life activity must submit documentation from a licensed health professional (physician, psychiatrist, or other specialist) in order to establish eligibility for accommodation. The documentation must display the impact of the student's diagnosis on the educational experience and recommend the accommodations necessary to provide the student equal access in the academic setting.

Submit this verification form through the OAS's Secure File Transfer Form for Health Care Practitioners or return it to the student named above.

DIAGNOSIS INFORMATION

Diagnosis in the area(s) of: ☐ ADHD ☐ Psychiatric ☐ Learning ☐ Medical

Primary Diagnosis(es) and results of evaluation (medical / DSM-IV or -V): _____

_____

Date of establishment / Age of onset ___ /___ /_____ Diagnosed by (provider's name) _____

Initial evaluation method(s): _____

Date of most recent evaluation ___ /___ /_____ Evaluation type: ☐ Psycho-educational ☐ Disability-related

Evaluation method(s): _____

Schedule for re-evaluation: _____

BACKGROUND HISTORY

Please discuss any pertinent background information related to the diagnosis.

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_____

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EVALUATION PROCEDURES

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Please list assessment or evaluation procedures, results, and any additional information related to the evaluation of the student's disability. (e.g. specific testing, weekly therapy, check-in appointments)

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CURRENT IMPACT OF DIAGNOSIS

Please describe the student's condition. We ask that you include how the condition impacts the student and the student's educational history, level of impairment, progress and/or treatment as applicable.

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Severity of symptoms: ☐ Mild ☐ Moderate ☐ Severe

IMPACT ON MAJOR LIFE ACTIVITY IN ACADEMIC SETTING

Does the diagnosis constitute a *current and substantial* limitation on a major life activity (i.e. learning)?

☐ YES ☐ NO

Please describe the limitations on learning and the degree to which the student's disability impacts academic performance and the student's ability to meet the demands of the academic program.

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CURRENT MEDICATIONS AND TREATMENT

Please list any prescribed medications, their dosages, and any adverse side effects, if applicable.

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_____

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_____

Condition is: ☐ Stable ☐ Prone to exacerbation ☐ Permanent/chronic ☐ Temporary

RECOMMENDATIONS / ADDITIONAL COMMENTS

Please provide a list of recommended accommodations and how they will address the student's specific needs for a fair and equal opportunity to learn relative to same-aged college peers. Specific accommodations will be determined and approved by the Office of Accessibility Services.

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EVALUATOR QUALIFICATIONS

I understand that the information provided will become part of the student record and may be released to the student upon the student's written request.

Printed Name of Verifying Evaluator _____ Signature _____

Title _____ License Number _____ Date ___ /___ /_____

Address _____ Phone _____

City, State, Zip Code _____ Fax _____

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Office of Accessibility Services

This form may also be submitted digitally through our secure file transfer link:

https://filetransfer.simmons.edu/form/OAS-Academic

Email access@simmons.edu with any questions.