Student Name: _____

James Madison University
Disability Services
VERIFICATION OF MEDICAL or PSYCHOLOGICAL CONDITION OR DISABILITY
To Support Student's Request for Accommodations of Disability at the University

To Be Completed by the Appropriate Treating Clinician
The report from a current, comprehensive, age-appropriate psycho-educational evaluation is most appropriate to support accommodations for Learning Disabilities and ADD/ADHD. Students should submit other relevant information about their history of experience with academic accommodations such as IEP's, relevant military records, or evaluations for assistive technology.

Date: _____

Name of Student (PLEASE PRINT): _____

Date of Birth: _____

Address: _____

_____

Phone: _____

Please answer these questions with the goal of providing information that will help the school to understand the student's current level of functioning, limitations, and associated need for accommodations of disability. You may also report on letter head as needed. *(If mandatory fields are left blank, more information may be requested in order to understand the student's difficulties. If diagnostic process is not complete, share something about what is known of the patient's symptoms and problems.)*

1. **MANDATORY:**
   Diagnoses/Description of Medical Conditions, Psychological Disorders or Primary Disabilities.

Please provide ICD-10 and/or DSM-5 code(s), as appropriate. DIAGNOSES:
Original date of diagnosis:
Date of most recent treatment or diagnosis:

In addition to ICD-10 and/or DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student in the university environment.

- ☐ Structured or unstructured interview with student
- ☐ Interviews with other knowledgeable parties
- ☐ Behavioral observations
- ☐ Review of educational records, including history of use of accommodations
- ☐ Medical history
- ☐ Neuro-psychological testing (date of testing: _____)
- ☐ Psycho-educational testing (date of testing:_____)
- ☐ Standardized or non-standardized rating scales
- ☐ Other (please specify):

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2. **MANDATORY: The prognosis for the medical condition or disability above is:**

- ☐ Permanent/Chronic
- ☐ Long term: 6-12 months
- ☐ Short-term/Temporary: 6 months or less Expected duration: _____
- ☐ Episodic (please describe) _____

What is the severity of the condition? Please check one:

☐ Mild ☐ Moderate ☐ Severe

Describe the expected **progression or stability** of the condition over time, particularly the next four to five years. (This description should provide an estimate of the change in the functional limitations of the disability over time and/or recommendations concerning the predictable needs to review circumstances to ensure needs are appropriately addressed.)

3. **To help in determining the need for accommodations, please describe the positive and negative impact of mitigating measures including current treatment(s)/therapy, assistive devices, and prescribed medications.** *("For example, someone with diabetes may need breaks to take insulin and monitor blood sugar levels, and someone with kidney disease may need a modified work schedule to receive dialysis treatments. On the other hand, if an individual with a disability uses a mitigating measure that results in no negative effects and eliminates the need for a reasonable accommodation, a covered entity will have no obligation to provide one." http://www.eeoc.gov/laws/regulations/ada_qa_final_rule.cfm)*

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*"**Major bodily functions**" include, but are not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.*

*"**Major life activities**" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.*

4. **MANDATORY: Does this individual's condition substantially impact major bodily functions or limit him or her in a major life activity**?

☐ *NO—If there is negligible impact or no limitations to bodily functions or major life activities, accommodations are not needed.*

☐ **Yes—If yes, please specify what functions or activities are involved and the severity of current impairment. Accommodations are related to current limitations and the severity of the impairment.**

Functional Limitations and Current Impact or Severity:

Life Activity/Functions	Negligible	Moderate	Substantial	Don't Know
Seeing				
Hearing				
Walking				
Sitting				
Standing				
Learning				
Reading				
Concentrating				
Thinking				
Organizing information/materials				
Managing Internal Distraction				
Managing External Distractions				
Self-care				
Speaking				
Sleeping				
Breathing				
Working				
OTHER (Please specify):				

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Other symptoms that may impact functioning or be limiting in the academic environment:

Cognitive Limitations

_____ Long term memory

_____ Short term memory

_____ Effect of anxiety on cognitive functioning

_____ Concentration problems

_____ Distractibility

_____ Difficulty in adapting to new learning situations

_____ Other (specify):

_____

Perceptional Limitations

_____ Visual hallucinations

_____ Auditory hallucinations

_____ Other (specify)

Behavior/Interpersonal Limitations

_____ Time management problems
_____ Restricted or labile affect in daily social activity
_____ Impulsivity
_____ Excessive activity level
_____ Fatigue or low energy
_____ Frequent emotional outburst
_____ Irritability
_____ Restlessness
_____ Interpersonal fears or suspiciousness
_____ Preoccupation with self (i.e. overly concerned with one's health or well-being)
_____ Rambling, halting, weak, or pressured speech
_____ Self -talk
_____ Difficulty initiating interpersonal contact
_____ Difficulty in adapting to new learning situations
_____ Other (specify):

_____

_____ **NONE**

Medication Side Effects

_____ Drowsiness
_____ Fatigue
_____ Thirst
_____ Blurred vision
_____ Hand tremors
_____ Other (specify)

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5. **Student's History and use of Academic Accommodations**: Please share information about accommodations that have been used effectively in the past. Include copies of other documentation such as 504 plans or IEP's or letters from ETS about accommodations provided on tests such as SAT or ACT as evidence of effective implementation of accommodations from past academic settings.

6. **MANDATORY: Please list any academic, housing, or other accommodation(s) you recommend and the reason(s) for the recommendation.** Use additional pages as needed.
    a. Accommodation recommendations should flow logically from the current functional impairment(s) that point to the need for modifications.
    b. Explain how accommodation(s) or modifications will ease the impact of the disability in the collegiate environment.
    c. If accommodations have not been used or approved in the past, explain what has occurred to prompt the current recommendation for accommodations.

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7. Please use the space below (and additional sheets as needed) to provide any other information that will be helpful to University staff in considering the accommodations that you are recommending. You may choose to address these questions or other relevant concerns:
    a. Is impact of the condition threatening if the request is not met?
    b. Is there a negative health impact that may be permanent if the request is not met?
    c. Is the request an integral component of a treatment plan for the condition in questions?
    d. What is the likely impact on academic performance if the request is not met?
    e. What is the likely impact on social development if the request is not met?
    f. What is the likely impact on the student's level of comfort if the request is not met?

All recommendations are considered. Potentially effective alternatives may be considered as needed. Decisions are made based on the nature of the disability and functional limitations, reasonableness of the request, academic integrity and available housing.

Signature indicates that complete records are on file with the Treating Clinician at the below location and will be available for clarification upon request, and the Treating Clinician is not a family member of the student.

Please include any available releases the student has signed authorizing communication between JMU's Office of Disability Services and the clinician or treating provider who is submitting this verification and any supporting documentation.

_____
Signature of Treating Clinician Date

_____
Name (Please Print)

_____
Title

_____
Name of Agency

_____
Phone Number

_____
Street Address

_____
City/State/Zip

Please Return To: Office of Disability Services
MSC 1009
Student Success Center, Suite 1202
Harrisonburg, VA 22807
Phone: 540-568-6705 FAX: 540-568-7099

Portions of this document were adapted from a similar forms developed by the Office for Disability Services at the Ohio State University, with permission, June 2012, and from the Student Disability Access Center at the University of Virginia with permission October 2017.