

VERIFICATION OF DISABILITY

To Support Student's Request for Accommodations at the University

To Be Completed by a Licensed Provider

Under the Americans with Disabilities Act (ADA), as amended, Section 504 of the Rehabilitation Act, and the Fair Housing Act (FHA), qualified individuals with disabilities may be entitled to reasonable accommodations and services to ensure equal access to the University's programs and activities.

To determine eligibility for reasonable accommodations and services, the Office of Disability Services (ODS) requires documentation that establishes the student as a person with a disability.

Documentation should provide current evidence that the student's condition(s) significantly impact(s) one or more major life activities and demonstrate a direct connection between the nature of the condition, the student's access needs, and the recommended accommodation(s).

This Verification of Disability form, or a letter that addresses all components within this form, serves as one option for providing documentation of disability to ODS. In some cases, different and/or additional documentation may be needed to reach a determination. For more information, please review our [Documentation Guidelines](#) or contact us at disability-svcs@jmu.edu or (540) 568-6705.

Form Instructions:

- The person completing this form should be a **licensed provider** who is qualified to assess, diagnose, and/or treat the student's condition.
 - Examples include the student's primary care provider, psychiatrist, therapist, optometrist, audiologist, speech-language pathologist, medical doctor, etc.
- To avoid any conflict of interest, ODS cannot accept forms completed by family members, close relatives, and/or people not acting in a professional capacity with the student.
- Reasonable accommodations and services can only be provided for disability-related needs. This form is not intended to be used for non-disability related requests such as financial challenges, roommate issues, work schedule conflicts, family obligations, etc.
- **For Licensed Providers:** Please complete all parts of this form as it relates to the student (your patient). Inadequate information, broad generalizations, missing fields, or illegible handwriting may delay our determination of reasonable accommodations. If the diagnostic process is not complete, please share what you know so far about the student's symptoms, including how these symptoms limit the student's participation in major life activities.

Student Information

Name (*print*): _____ Phone: _____

Date of Birth: _____ JMU ID #: _____

Diagnosis & Description of Condition(s)

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Please list all relevant diagnoses, including ICD-10 and/or DSM-5 code(s):

Original date of diagnosis:

Date of most recent treatment or diagnosis:

How did you arrive at your diagnosis? (*select all that apply*)

- | | |
|--|---|
| ☐ Interview with student | ☐ Neuro-psychological testing (<i>date</i>): |
| ☐ Interviews with other knowledgeable parties | ☐ Psycho-educational testing (<i>date</i>): |
| ☐ Behavioral observations | ☐ Standardized rating scales |
| ☐ Review of educational records, including prior use of accommodations (504 Plan/IEP) | ☐ Laboratory tests |
| ☐ Medical history | ☐ Imaging |
| ☐ Developmental history | ☐ Other (<i>describe</i>): |

What is the current prognosis of the condition(s)? (*select all that apply*)

- ☐
- Permanent/Chronic

Do you expect the condition(s) to persist over the next 4-5 years? ☐ No ☐ Yes

- ☐
- Long term (6-12 months)

Expected duration:
When is the next follow up with the student?

- ☐
- Short-term/Temporary (6 months or less)

Expected duration:
When is the next follow up with the student?

- ☐
- Episodic

Frequency of flare-ups/symptom occurrence:
Typical duration of a flare-up/symptom occurrence:
Known triggers:

Additional Comments:

What is the current severity of the condition(s)?

☐ Residual/In Remission ☐ Mild ☐ Moderate ☐ Severe

Additional Comments:

Do you expect the severity of the condition(s) to change over time (including periodic fluctuations)?

☐ No ☐ Yes (*describe*):

To manage their condition(s) is the student currently 1) using any prescribed medications, assistive technology, or mobility devices and/or 2) engaging in any treatments, therapies, or lifestyle changes?

☐ No

☐ Yes (*answer the following questions, as applicable*)

1. Does the student experience any medication side effects that limit their ability to complete major life activities or academic tasks? ☐ No ☐ Yes (*describe*):

2. Please specify any assistive technology or mobility devices that the student is currently using.

Additional Comments:

Functional Limitations

Please indicate in the table below:

- 1) The extent to which the student's condition(s) impact(s) their ability to perform each major life activity/task.
- 2) Any accommodation(s) you recommend to help mitigate the impact of the student's condition(s) on the major life activity/task and your rationale.

Legend: 1 – Mild Impact 2- Moderate Impact 3- Substantial Impact

**If you don't select an option, you are indicating that there is no impact.*

Major Life Activity/ Task	1	2	3	Recommended Accommodation(s) & Rationale
Academic-Related				
Reading	☐	☐	☐	
Writing	☐	☐	☐	
Typing	☐	☐	☐	
Using a computer	☐	☐	☐	
Concentrating	☐	☐	☐	
Processing information	☐	☐	☐	
Remembering/Recalling information (memory)	☐	☐	☐	
Planning/ Time management	☐	☐	☐	
Organizing information/materials	☐	☐	☐	
Managing Internal Distractions	☐	☐	☐	
Managing External Distractions	☐	☐	☐	
Social & Emotional				
Interacting with others	☐	☐	☐	
Adapting to change	☐	☐	☐	
Managing impulses	☐	☐	☐	
Regulating emotions and/or thoughts	☐	☐	☐	

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Student Name: _____

Signature

Your signature below indicates that 1) complete records are on file with you/your practice at the below listed address 2) you are not a family member or close relative of the student 3) you acted in a professional capacity when completing this form.

Signature of Licensed Provider_____
Date_____
Printed Name of Licensed Provider_____
Title/Credentials_____
Name of Practice_____
Phone Number_____
Email_____
Fax Number_____
Street Address_____
City/State/Zip**Please return this form to the Office of Disability Services by:**

Mail: MSC 1009
Student Success Center, Suite 1202
Harrisonburg, VA 22807

Fax: 540-568-7099
Email: disability-svcs@jmu.edu