



FERRIS STATE UNIVERSITY

Educational and Career Counseling Center and Disabilities Services

MEDICAL, PHYSICAL and/or SENSORY DISABILITY PROFESSIONAL DOCUMENTATION/VERIFICATION FORM

This form is for physical, medical or sensory conditions only. Autism Spectrum/Pervasive Developmental Disorders require completion of the *Autism Spectrum/Pervasive Developmental Disorder Documentation/Verification Form*; Psychiatric/Psychological Disabilities require the completion of the *Psychiatric/Psychological Disability Documentation/Verification Form*; ADD/ADHD conditions require the completion of the *ADD/ADHD Verification Form* and the *Physicians Statement of Long Term Medical, Physical and/or Sensory Documentation/Verification Form*.

PLEASE REVIEW CAREFULLY

The student named below has applied for accommodations from Ferris State University. Students seeking accommodations must provide appropriate medical documentation of their condition so that the University can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

Documentation required to verify the student's condition and its severity, includes completion of this form or provision of equivalent information to Disabilities Services by a medical professional with the appropriate training and credentials. Any professional completing this form must have first-hand knowledge of the student's condition, experience in working with students with the stated condition(s) and a familiarity with the physical, emotional and cognitive demands experienced by students in an academic setting. Diagnoses by family members are unacceptable.

Disabilities Services at Ferris State University provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. A disability must substantially limit one or more major life activity, such as walking, seeing, hearing, speaking, breathing, learning, performing manual tasks and working.

Current and comprehensive disability documentation is required to assist with the provision of appropriate and reasonable accommodations and/or auxiliary aids. Additional documentation may be required.

**Ferris State University / University College / Department Head
Educational and Career Counseling Center & Disabilities Services
901 S State Street, Starr 313
Big Rapids, Michigan 49307
Phone & TDD (231) 591-3057 Fax (231) 591-3939
E-mail: disabilities@ferris.edu**



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Physician's Statement of Long-Term Medical, Physical and/or Sensory Disability Documentation/Verification

Student: Complete this section.

Last Name _____ First Name _____ M.I. _____

Campus Wide I.D. (CWID): _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____, authorize the identified health care provider to release to Disabilities Services the medical information requested on this form for the purpose of determining appropriate accommodation for my permanent or temporary disability while a student at Ferris State University. I also authorize my provider to discuss my disability with the Disabilities Services Counseling Staff for clarification and continuity of care.

Signature of patient: _____ Date: _____

If under 18 and/or signed by person other than patient, state relationship and authority to do so.

Relationship: _____ Legal Authority: _____

Certifying Professional: Complete this section including the back of this sheet

Today's Date: _____

Printed Name: _____

Signature: _____

Signature denotes: content accuracy, adherence to professional standards and guidelines as stated above.

License Type: _____

License Number: _____ State _____ Exp Date _____

Area of Medicine: _____ Title: _____

Mailing Address: _____

City/State/Zip: _____

Phone: (_____) _____ Fax: (_____) _____



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State your diagnosis(es) and provide a description of the client's medical condition/symptoms (include ICD-9, ICD-10 or DSM-IV Code): _____

Date of onset/DX: _____ Severity of Condition: Mild Moderate Severe In Remission

Procedures/assessments used to diagnose this student's condition: _____

Is there a periodic evaluation of the individual's condition? _____ If so, how often? _____

The medical condition or disability is: Permanent/chronic
Long-term 6-12 months
Short-term/temporary: 6 months or less
Expected Duration _____

What are the functional limitations of this individual? _____

List and describe any prescribed medications (including dosage) and prescribed aides (i.e., eyeglasses, hearing aids, mobility aides) used in the treatment of this condition: _____

If the individual is taking medication, what are the effects? _____

Identify any functional limitations/restrictions that remain even with the treatment listed previously (Please be descriptive and specific. This information will help us better understand your patient's condition): _____

How does the individual's condition and/or medication affect his/her learning? _____

Recommended accommodation and/or auxiliary aids (must be clearly linked to functional limitations): _____

Anticipated Duration of Accommodation: _____

