FERRIS STATE UNIVERSITY

Educational Counseling and Disabilities Services

Verification of Disability For Academic Accommodations Form

This form can be used for sensory, chronic health conditions, orthopedic and mobility impairments, other health impairments, and traumatic brain injuries. It **may** be used for a range of conditions, but some of these disorders may require additional documentation, including **psychometric or other testing**. Testing and general documentation requirements can be found at: http://www.ferris.edu/HTMLS/colleges/university/disability/checklist/checksheet.htm.

Professional Provider: Please Review Carefully

The student named below is requesting disability-related academic accommodations from Ferris State University. Students seeking accommodations should provide sufficient evidence of their condition so that the University can: a) **verify** the existence of a condition or disability, b) **determine** if the condition impairs a major life activity c) **discuss** appropriate accommodations with the student.

Documentation required to verify the student's condition and its severity, includes the completion of this form **or the provision of equivalent information to Educational Counseling and Disabilities Services** by a health care or clinical professional with the appropriate training and credentials, on letterhead. 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 demands experienced by students in an academic setting. Diagnoses by family members are unacceptable.

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

All documentation is confidential (to the extent protected by law) and should be submitted to the below address.

Ferris State University / Retention and Student Success / Department Head
Educational Counseling & Disabilities Services
Arts & Sciences Commons 1017
Big Rapids, Michigan 49307
Phone (231) 591-3057 Fax (231) 591-3939 (confidential fax)
E-mail: ecds@ferris.edu

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Student: Complete this section.

Last Name: _____ First Name: _____ M.I.: ___

Student ID Number: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

AUTHORIZATION TO RELEASE MEDICAL/PSYCHOLOGICAL/PSYCHIATRIC INFORMATION TO FERRIS EDUCATIONAL COUNSELING AND DISABILITIES SERVICES

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 Educational Counseling and 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: _____

Ferris State University, Educational Counseling and Disabilities Services, ASC 1017, Big Rapids, Michigan, 49307 Phone (231) 591-3057, FAX (231) 591-3939, E-mail: ecds@ferris.edu

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

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, if known: _____

Severity of Condition: Mild Moderate Severe In Remission
(NOTE: Condition must be 'Substantially Limiting')

The medical condition or disability is: Permanent/chronic
Long-term: 6-12 months
Expected duration: _____

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

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

What are the functional limitations of this individual? _____
_____
_____
_____

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

Medication and side effects? _____
_____
_____

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

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

_____

_____

_____

_____

Anticipated Duration of Accommodation Need: _____

Optional comments: Please use the space below (and additional sheets as needed) to provide any information that will be helpful to the Educational Counseling and Disabilities Services staff in considering the student's request, need for accommodations, and suggestions you may have:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for completing this form and helping the student with their academic accommodation needs.

All documentation is confidential (to the extent protected by law) and should be submitted to the below address.

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