University of CINCINNATI

Accessibility Resources
Division of Student Affairs
University of Cincinnati
PO Box 210213
Cincinnati, OH 45221-0213
210 University Pavilion
Telephone: 513-556-6823
Fax: 513-556-1383

Medical Professional Disability Verification Form

(Note: This Form should be completed by a qualified medical professional. Not the student.)

Dear Medical Professional:

The University of Cincinnati Accessibility Resource (AR) office responsibility is to provide reasonable and appropriate accommodations to students with disabilities which would lessen the impact of the disability within the academic setting. Documentation must be provided by a qualified medical professional i.e., someone with direct experience specific to a disability diagnosis and approved through Accessibility Resources. For example, documentation from an Optometrist (eye specialist) denoting that a student has a mental health condition would not be accepted. The purpose of this form is to assist qualified medical professionals with documenting relevant information regarding a student's disability and its impact in order to help determine eligibility for accommodations.

This form is one option for providing information about a student's disability. Other appropriate forms of documentation would include: a letter from a qualified medical professional letter, individual Education Program (IEP), 504 Plan, Summary of Performance (SOP), Teacher Observations, full psychological evaluations, psycho-educational evaluations (with test scores), physician's medical records, etc. Accessibility Resources requires documentation that includes:

1. A diagnosis of disability that limits a major life activity;
2. A description of how the condition will impact the student within the academic environment;
3. A listing of reasonable, appropriate accommodations that will lessen the impact of the disability within the academic setting.

Please take note of the following as you complete this form:

1. **The person completing this form should be a qualified medical professional who is (1) qualified to assess and diagnose the student's condition, and/or (2) was a part of the student's treatment plan for a previously diagnosed condition.** Examples of these professionals include: psychiatrist, psychologist, therapist, medical doctor, optometrist**,** etc.

2. **Please complete all parts of this form legibly and as thoroughly as possible.** Inadequate information, illegible handwriting, or missing fields will delay the review process by necessitating follow up contact for clarification. This PDF provides fillable form fields to allow for typed answers. Typed answers are highly recommended.

3. **Please attach any additional documents or information you think would be relevant in determining the student's eligibility for accommodations.**

To help support the student's request, please return this form to the student upon completion so that they may upload with their online request form. If you have questions about this form, please contact Accessibility Resources via email accessresoruces@uc.edu or by calling (513)556-6823.

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Medical Professional Disability Verification Form

Student's Full Name _____

Date of Birth _____ Date of last contact _____

I, the undersigned diagnostic/treating professional, certify that the above named student: **(Check One)**

☐ Meets the definition of a disability as defined by the American's with Disabilities Act & Section 504 of the Rehabilitation Act of 1973.
☐ Has a medical condition that impacts them but does not rise to the level of a disability,
☐ Does not have a condition that would require the requested modification(s).

1. List the student's disability/medical condition and current symptoms:

2. Provide a detailed explanation of how the disability impacts the student's ability to function within an academic environment. Please speak to the student's specific experience and not to generalities related to the diagnosis.

This form must be returned to the student for them to upload with their online request form.
Please type or print answers.

3. Expected duration of disability and its impact on the student within academic environment.
   ☐Permanent ☐Temporary ☐Remitting/relapsing
   If temporary or remitting/relapsing, please explain expected duration of impact on the student.

4. How are symptoms/disability currently being treated or controlled? Describe other medical treatments, therapies, devices, or regimens prescribed including compliance, and response to intervention.

5. What accommodations are recommended to mitigate or eliminate the impact of the disability on the student's academic life? Accommodations are provided on a case-by-case basis and are not limited to the list below.

☐None
☐Extended Time on Testing: 50%
☐Extended Time on Testing: 100%
☐Distraction Reduced Testing Environment
☐Individual testing room
☐Reader
☐Scribe
☐Use of computer (class or testing)
☐Enlarged Font
☐FM system
☐ASL Interpreter
☐Captioning
☐Communication Access Realtime Translation (CART)
☐Accessible Furniture
☐Excused Medical Absences
☐Extended Time on Assignments
☐ Readings in Alternative Format
☐Tape recorder
☐Notetaker
☐Assistive Technology (list)
☐ Other (list)

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Please type or print answers.

6. Please explain the rationale as to why each recommended accommodation is warranted and how it will diminish the impact of the disability on the student's academic experience.

7. Has the student been prescribed medication for the disability that may impact their academic abilities? If so, please explain.

8. Are there specialty evaluations or reports (e.g. neuropsychological, psychiatric, vision, hearing, speech, physical therapy, occupational therapy, etc.), pertinent to the student's functioning in an academic environment? Please include a copy if possible, or identify the service provider so AR can discuss it with the student.

9. Please provide any additional information pertinent to the student's request for academic accommodation.

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Please type or print answers.

CERTIFYING PROFESSIONAL

Name & Title: _____

Place of Employment: _____

Address: _____

_____

Daytime Phone _____

Fax Number _____

Specialty or license: _____

_____ _____

Signature of Certifying Professional Date

_____ _____

Print Name License #/State Date

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Please type or print answers.