

Note:

Documentation will not

be accepted without a Doctor’s business card or official office stamp.

**Office of Disability Services**

1000 Morris Ave Union NJ 07083 TEL: (908) 737-4910 FAX: (908) 737-4865 EMAIL: [disabilityservices@kean.edu](mailto:disabilityservices@kean.edu)

**Verification of Medical/Psychiatric Conditions**

**The provider who completes this form must be a licensed professional in the State of New Jersey or the student’s home state, who has relevant training and experience diagnosing and treating the reported condition, is unrelated to the individual being evaluated and has a history of providing treatment to the student and/or has an ongoing therapeutic relationship.**

The student named below has applied for services from the Office of Disability Services at Kean University. In order to determine eligibility and to provide services, we require documentation of the student’s disability.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Date of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last date of Clinical Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Disability/Condition: □ Permanent □Temporary

If temporary, include expected recovery time: □ 1 month □ 6 month □ 1 year   
  
 □ other: please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What impact does the illness have on the patient’s ability to perform college level academic work**? **Be specific.**

Use space provided or please write on professional letterhead if additional sheets are needed.

In your professional judgment, to what extent will the condition impact the student’s academic functioning?

□ Totally Incapacitated:

Patient should \_\_\_\_ not register\_\_\_\_\_ withdraw from college until:

Day \_\_\_\_\_\_\_\_\_\_Month \_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_

□ Partially Incapacitated:

Patient should \_\_\_\_\_\_reduce his/her course load or \_\_\_\_\_\_ (other: please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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□ Minimally Incapacitated:

Patient is expected to function adequately with the following reasonable accommodations:

Please list any medications patient is currently taking. (Please include dosage and frequency).

1.

2.

3.

What potential side effects are associated with the medication(s)?

Date of next assessment: Day \_\_\_\_\_\_\_\_\_ Month\_\_\_\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_\_\_

**Proposed Treatment Plan**:

(If treatment plan includes study skills workshops, career or personal counseling sessions, etc., student is expected to follow through with these activities.)

**Note: Should the student’s condition change (for better or worse), the student must provide updated documentation so his/her accommodations will be adjusted accordingly**.

Name and contact information for licensed professional

(**please use office stamp- or attach business card**)

Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Unless students provide us with proper documentation, the Kean University Office of Disability Services cannot implement any services for them.***

**We ask that you return this form to:**

**Office of Disability Services**

**Kean University**

**1000 Morris Avenue, Downs Hall Room 122**

**Union, NJ 07083**

**Fax: 908-737-4865 or** [**disabilityservices@kean.edu**](mailto:disabilityservices@kean.edu)