# Disability Verification Form for Medical Providers

Revised 5/2025

**Purpose:** The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Kean University. The information you provide will be one of the criteria used to evaluate the student’s eligibility for the requested accommodations or services. Please complete this form in its entirety. All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

## Student Information:

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| Student’s First Name: |  |
| Student’s Last Name: |  |

**The remainder of this document must be completed by a certified/licensed Health Care Provider.**

Date of First Diagnosis: Click or tap to enter a date.

Date Student was first seen: Click or tap to enter a date.

Date Student was last seen: Click or tap to enter a date.

How long have you been treating the student?

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## **Medical Condition Information:**

Diagnosis and description of the student’s medical condition:

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Frequency of appointments:

Once a week

Twice a week

Once a month

Once every six months

Once a year

As-needed

What is the severity of the condition?

Mild

Moderate

Severe

Explain the severity selected above:

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What is the expected duration of the condition?

Short-term (less than six months)

Episodic

Long-term (6 months to one year)

Chronic (longer than one year with frequent recurrence)

Is the student able to ambulate?  Yes  No

Can the student negotiate stairs, or is an elevator required? Please explain.

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## **Psychological Condition Information:**

DSM-5 Diagnosis/ICD-10 Code(s)

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What is the expected duration of the condition?

Short-term (less than 6 months)

Episodic

Long-term (6 months - 1 year)

Chronic (longer than 1 year with frequent recurrence)

In addition to the DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items.

Structured or unstructured interviews with the person him/herself

Interviews with other persons

Behavioral observations

Developmental history

Educational history

Medical history

Neuropsychological testing

Psychoeducational testing

Standardized or unstandardized rating scales

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| Other: |  |

If you selected Neuropsychological Testing, please provide the testing date: Click or tap to enter a date.

If you selected Psychoeducational Testing, please provide the testing date: Click or tap to enter a date.

## **Functional Limitations**

|  | **No impact** | **Moderate impact** | **Substantial impact** | **Don’t Know** |
| --- | --- | --- | --- | --- |
| Concentration |  |  |  |  |
| Memory |  |  |  |  |
| Sleep/Waking |  |  |  |  |
| Eating |  |  |  |  |
| Social interaction |  |  |  |  |
| Self-Care |  |  |  |  |
| Managing internal Distractions |  |  |  |  |
| Managing external distractions |  |  |  |  |
| Complex/Abstract thinking |  |  |  |  |
| Attending class regularly and on time |  |  |  |  |
| Making and keeping appointments |  |  |  |  |
| Stress management |  |  |  |  |
| Organization and prioritization of task(s) |  |  |  |  |
| Stress management |  |  |  |  |
| Other |  |  |  |  |

If patient is taking medication, how does it impact the functional limitations listed above?

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## **Symptoms and Accommodations**

Please list the student’s current symptoms. Then, indicate what reasonable academic accommodations would be related to the symptom indicated. (More detailed information regarding reasonable academic accommodations can be found at: reasonable accommodations).

**Example:** Symptom: “Due to the student’s Crohn's Disorder, the student has frequent stomach pain and is required to use the restroom numerous times throughout the day. Often this is an emergency type of frequency and may affect attendance.”

**Recommended Reasonable Accommodation:** “Student will require frequent breaks, consideration of attendance policies, and possibly breaks during quizzes or exams as necessary without penalty."

**Symptom 1**

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**Recommended Reasonable Accommodation**

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**Symptom 2**

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**Recommended Reasonable Accommodation**

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**Symptom 3**

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**Recommended Reasonable Accommodation**

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**Symptom 4**

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**Recommended Reasonable Accommodation**

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## **Medication**

Is the student currently taking any medication?  Yes  No

If yes, please provide information on each medication below:

(e.g., Celebrex, 200 mg, 1x daily, 1/1/2020, Dr. John Doe)

**Medication 1, Dosage, & Frequency**

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| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
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| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
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**Medication 2, Dosage, & Frequency**

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| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
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| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
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**Medication 3, Dosage, & Frequency**

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| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
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| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
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**Additional Medication Comments:**

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Note: Please attach any supporting documentation that you feel can assist our office in the determination of reasonable accommodations.

**HEALTH CARE PROVIDER COMPLETING THIS FORM:**

Role of the individual completing this form (check all that apply).

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| Medical Doctor | | Nurse Practitioner |
| Dentist | | Advanced Practice Registered Nurse |
| Physician Assistant | | Psychiatric Nurse Practitioner |
| Other: |  | |

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| Facility/Company Name:  Provider Full Name: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| License Number: | |  | |
| Title/Profession: | |  | |
| Street Address: | |  | |
| City, State, Zip | |  | |
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| Phone Number: | |  | |
| E-mail Address: | |  | |
| Provider Signature: |  | |

**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **PROVIDER – Please include office stamp for authentication. If your office does not use an office stamp, please indicate this below in the stamp here box. Include copies of evaluation and diagnostic evaluations reports for each area of disability.**
* **PROVIDER AND STUDENT – This Disability Verification Form serves as proper medical documentation for the above mentioned student. If for any reason, this form cannot be completed, the Kean University Office of Accessibility Services cannot implement services for this student. Please contact us with any questions at (908) 737-4910 or** [**accessibilityservices@kean.edu**](mailto:accessibilityservices@kean.edu)

**Please return this form to the student for submission.**

**Stamp Here:**