UNION COLLEGE
FOUNDED 1795

Tel. (518) 388-8785
Email: accommodations@union.edu
ACCOMMODATIVE SERVICES OFFICE

Medical Disability Verification Form

The student named below has applied for services from the Accommodative Services Office (ASO) at Union College. To determine eligibility and to provide services, we require documentation of the student's medical disability. **This form should not be used to support a request for accommodations based on a diagnosis of ADHD, other health impairment, specific learning disability or psychological disability.**

Under the Americans with Disabilities Act as amended and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodation. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please print it, sign it, and email it to us at the email address in our letterhead. The information you provide will not become part of the student's educational records but will be kept in the student's file at ASO, where it will be held strictly confidential. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant. Please contact us if you have questions or concerns. Thank you for your assistance.

RELEASE OF INFORMATION

I,__________________________________, hereby authorize the release of the following information to the Accommodative Services Office at Union College for the purpose of determining my eligibility for academic accommodations.

Student ID #: _______________________________ Date: _______________________

Signature: ____

TO BE COMPLETED BY LICENSED PROVIDER

Please list the diagnosis(es): ____

____

Date of diagnosis(es): ____

Date of last contact with student: _______________________________________

Is the student currently under your care? ▢ Yes ▢ No

Medication prescribed: ▢ Yes ▢ No If yes, what?

____

____

If so, by whom? ____

Frequency of monitoring: ____

How will refills be obtained? ____

Effect of medication on academic functioning and side effects:

____

Do limitations/symptoms persist even with medication? ▢ Yes ▢ No

If the student is currently undergoing medical treatment, please describe how the treatment might affect the student academically.

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Major Life Activities Assessment:

- *Please check which of the following major life activities listed below are affected because of the diagnosis. Please indicate severity of limitations.*

Life Activity	**No Impact**	**Minor Impact**	**Moderate Impact**	**Substantial Impact**
Caring for oneself				
Talking				
Hearing				
Breathing				

Life Activity	No Impact	Minor Impact	Moderate Impact	Substantial Impact
Seeing				
Walking/Standing				
Lifting Carrying				
Sitting				
Performing Manual Tasks				
Eating				
Working				
Learning				
Reading				
Writing/Spelling				
Calculating				
Memorizing				
Concentrating				
Listening				
Other:___________________				

Please provide more information on any functional impact that is noted above specific to an academic setting (e.g., unable to type for more than ten minutes or unable to walk more than 50 feet without fatigue, etc.)?

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How long do you anticipate the student's academic achievement will be impacted by this diagnosis(es)?

▢ Six months ▢ One year ▢ One year +

Has the student been hospitalized in the past year in relation to the above diagnosis(es)? ▢ Yes ▢ No

Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

____

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____

Please attach any other relevant information you have which you feel we should know in order to help this student.

Thank you for your help in providing this information so that we might begin providing services as soon as possible. Please return this form to the email address shown on the letterhead or to the student.

LICENSED PROVIDER INFORMATION

(Please sign and date below and fill in all other fields completely using PRINT or TYPE)

Provider's Name: ____

License Number: ____

Address:____

Phone: ______________________ Email: __________________________

Signature: ______________________________ Date: ________________

Official Stamp: