

Medical Verification Form for Academic Accommodations

Instructions: This form must be completed by a licensed medical or mental health professional to verify a disability and recommend appropriate academic accommodations. Once completed, the student may print and submit this form to the Accessibility Services Office.

Section 1: Student Information

Student Full Name:

Student ID Number:

Date of Birth:

Phone Number:

Email Address:

Section 2: Certifying Professional Information

Professional Name and Title:

License / Certification Number & State:

Area of Specialization:

Clinic / Hospital / Organization Name:

Business Phone Number:

Business Email Address:

Section 3: Medical / Psychological Assessment

Diagnosis / Condition:

Date of Original Diagnosis:

Date of Last Professional Contact with Student:

Duration of Condition (e.g., Permanent, Temporary until MM/DD/YYYY):

Severity of Condition (e.g., Mild, Moderate, Severe):

Section 4: Impact on Academic Functioning

Please describe how the condition impacts the student's ability to perform the following academic tasks (type "N/A" if not applicable):

Taking Exams / Test Performance:

Reading and Processing Information:

Writing and Physical Fine Motor Tasks:

Attendance and Class Participation:

Concentration, Memory, and Focus:

Section 5: Recommended Accommodations

Identify specific accommodations that would help mitigate the limitations described above:

Testing Accommodations (e.g., Extended Time, Quiet Room):

Classroom Accommodations (e.g., Audio Recording, Note Taker):

Other / Specialized Equipment Recommendations:

Section 6: Professional Signature

By signing below, I certify that the information provided is true and accurate to the best of my knowledge, and that the student named above has a documented disability requiring accommodation.

Professional Signature (Or typed name for electronic verification):

Date Signed: