CONNECTICUT COLLEGE

STUDENT ACCESSIBILITY SERVICES

CERTIFICATION OF MEDICAL DISABILITY

The student named below has begun the process to request services with Student Accessibility Services at Connecticut College. To determine eligibility and provide services, we require documentation of the student's disability.

Under the Americans with Disabilities Act of 1990 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 accommodations. The documentation must also support the request for accommodations and academic adjustments.

RELEASE OF INFORMATION

I, (student print name) _____, hereby authorize the release of the following information to Student Accessibility Services at the Connecticut College for the purpose of determining my eligibility for educational accommodations.

_____	_____	_____
Student Signature	Camel ID#	Today's Date

MEDICAL DISABILITY VERIFICATION FORM

To the certifying professional:

Please complete the form below in as much detail as possible. Email or mail it directly to the Student Accessibility Services (SAS) using our contact information at the bottom of the page. The information you provide will not become part of the student's educational records. It will be kept in the student's file in the SAS, where it will be held strictly confidential. This form may be released to the student at his/her/their request. In addition to the desired information below, please attach any other information you feel would be relevant to the student's adjustment in the academic environment. Please contact the SAS if there are any questions or concerns.

1. Student's Name: _____ Date: _____
2. What is your diagnosis for this student? _____
3. Date of Above Diagnosis: _____
4. Date Last Seen: _____
5. Is the student currently under your care? ☐ Yes ☐ No
   How often is the patient required to be seen by you: _____
   (i.e. weekly, monthly, quarterly, yearly, as needed)
6. Is the student currently taking medication(s)? ☐ Yes ☐ No If yes, list current medication(s), impact and adverse side effects.

   _____

   _____
7. If the student is currently undergoing medical treatment, please describe how the treatment might impact the student academically.

   _____

   _____
8. Please check which of the major life activities listed below are impacted because of the medical disability. Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Talking	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Breathing	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Reaching	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Writing	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Concentration	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Other:	☐	☐	☐	☐

9. How long do you anticipate the student's academic achievement will be impacted by this disability?
   ☐ < Six Months ☐ One Year ☐ One Year +

10. Please state the student's functional limitations based on the medical diagnosis, specifically in a classroom or educational setting (i.e. problems sitting for long periods of time, unable to type for more than ten minutes).

_____

_____

_____

_____

11. Please list any specific recommendations regarding academic accommodations for this student and a rationale as to why these accommodations or services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

_____

_____

_____

_____

12. Additional Information:
    a. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?
    b. Is there anything else we should know about the student's medical disability?

_____

_____

_____

CERTIFYING PROFESSIONAL*

Professional's Name _____ Title _____

Name of Practice _____

Address _____

License No. _____ Email _____

Phone _____ Fax _____

Signature of Professional _____ Date _____

*Qualified diagnosing professionals are trained, certified or licensed healthcare professionals. The healthcare professional must have expertise in the differential diagnosis of the documented disability or condition and follow established practices in the field.