

Student Name: _____

Part II: Physician or Disability Evaluator Verification

Accommodations are only available to students identified as having a disability. **A disability is defined under the Americans with Disabilities Act as “a physical or mental impairment that substantially limits one or more major life activities.”** Examples of major life activities are: Major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

Please type answers or write clearly. Forms with illegible handwriting will be returned to student to resubmit.

1. Based on the definition above, does the individual have a disability? _____ Yes _____ No

Date of original diagnosis: _____ Date of most recent evaluation: _____

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

2. State the student’s disability diagnosis, including diagnostic code.

3. Describe the student’s functional limitations or behavioral manifestations caused by the condition. Please describe the type, severity, and frequency of symptoms related to this disability. What do you foresee as the impact living in a college residential hall setting?

4. What is the expected duration, stability, or progression of the student’s disability?

5. Please describe current treatments, prosthetic devices, and/or medications prescribed.



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6. Is this request medically necessary or is it recommended to enhance the comfort and/or convenience of the student? If medically necessary, please explain how the accommodation relates to the impact of the condition.

7. Is there a negative health impact that may be permanent if the request is not met? _____ Yes _____ No

If Yes, Please Explain: _____

8. Is the request an integral component of a treatment plan for the condition in question? _____ Yes _____ No

9. What is the likely impact on academic performance if the request is not met?

10. What is the likely impact on social development, if any, if the request is not met?

11. What is the likely impact on the student's level of comfort if the request is not met?



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THIS SECTION MUST BE COMPLETED FOR FORM TO BE VALID

Physician or disability evaluator INFORMATION (Please Print)

Name: _____

Title: _____ Specialty: _____

Office Address: _____

Phone: _____

License/Certification Number and State of License _____

How long have you treated this patient? _____

Date of most recent office visit? _____

May we contact you if we have questions about this student's accommodation request? _____ Yes _____ No

Signature: _____

Date: _____

PLEASE MAIL, FAX or EMAIL COMPLETED FORM

TO: Accessibility Resource

Center William Paterson

University

300 Pompton Road, Wayne, NJ 07470

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