SIU MEDICINE

Disability Verification Form

Student Information:

Name _____ Date of Birth _____

Address _____ City, State, Zip _____

Student ID _____ Phone Number _____

Email _____

I hereby authorize _____ to release/discuss the information below.

Signature of Student: _____ Date: _____

Purpose of Disability Verification:

Disability Support Services provides academic accommodations and services for students with documented disabilities. This completed verification form should provide enough information to clearly show the student has a disability as defined by Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (1990), and the ADA Amendments Act of 2008. The ADAAA defines a disability as a "physical or mental impairment that substantially limits one or more major life activities."

To assist in the process of determining academic accommodations and services for students with psychological, attention deficit, medical, sensory or health related conditions at SIU School of Medicine, current documentation of the student's disability or condition must be provided by a licensed professional (e.g. physician, psychiatrist, psychologist or certified social worker).

Diagnostic Information (Include DSM-5 diagnosis as applicable):

1. Primary Diagnosis

   _____

2. Secondary Diagnosis

   _____

3. Date of Diagnosis

   _____

4. Date of your last contact with the student.

   _____

5. What assessments/procedures were used to diagnose the disability?

   _____

6. Please describe the current symptoms of this disability and your on-going relationship regarding the student's treatment plan.

   _____

7. Is this student currently taking medication for this disability? ◯ Yes ◯ No

   If yes, what is the medication? _____

   Please describe any possible side effects of the medication.

   _____

Accommodation Recommendations:

1. Please describe the impact the disability has on the student with regard to the educational environment and/or access to university programs (e.g. concentration, information processing, writing, memory, reaching, walking, grasping, etc). This information will help to determine the specific academic adjustments and/or auxiliary aids which are necessary to ensure equal access.

   _____

   _____

   _____

2. Please state specific recommendations regarding academic accommodations for this student.

   _____

   _____

   _____

   ☐ Extended exam time

   ☐ Limited distraction environment for exams

   ☐ Bio

   ☐ Other _____

Additional Information and Provider Credentials:

Please attach any additional documentation that you believe to be relevant (e.g. psychological assessment, neuropsychological test results, Individualized Education Program, audiogram, vision evaluations, etc.).

Signature _____

Print Name and Title: _____

License # _____

Agency Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Date _____

Return form to:

SIU School of Medicine
Human Resources
Attn: Accommodation Requests
327 W. Calhoun Ave
Springfield, IL 62711

P: 217-545-7570
medstudentada@siumed.edu