



Disability Services
Salve Regina University
(401) 341-3150; Fax: (401) 341-2912

Certifying Physician or Specialist's Verification of Disability

Instructions: Please fill out this form in its entirety. Incomplete or missing information could result in a delay in the processing of the student's request for disability accommodations. Thank you!

Name of student: _____ Today's date: _____

Name of Certifying Professional: _____ Title: _____

Certification, training or licensure: _____ Specialty: _____

Diagnosis in the area(s) of: ADHD Learning Psychiatric Medical

Date last seen by your office relative to the disability in question: _____

When was the condition first diagnosed? _____ By whom: _____

Diagnosis/diagnoses or results of evaluation - medical or DSM-V (attach a copy of the evaluation or supportive documentation, if available):

Evaluation method used: _____

Date of last complete psycho-educational or disability-related evaluation (not a 504 Plan or IEP): _____

Does the condition constitute a ***current and substantial limitation*** of a major life activity (i.e. learning)? YES NO

Briefly describe the nature of the likely impact of the condition on the student's ability to live and learn in college:

Severity of symptoms: mild moderate severe

Condition is: stable prone to exacerbation temporary (explain) permanent/chronic

Treatment plan: Please include current, ongoing or follow-up care, *as well as prescribed medication*, and potential side effects:

Schedule for re-evaluation, if needed: _____

What supports will this student likely need to have a *fair and equal opportunity* to learn relative to same-aged, non-disabled college peers? (e.g. *extended time for test-taking, distraction-free setting for tests, e-texts, etc.*). Please note that *specific accommodations will be determined by the Disability Services office on the basis of documentation and clinical interview*):

Is there anything else we should know that has not been included above?

I understand that the information provided will become part of the student permanent record and will be released to the student upon his/her written request.

Certifying Professional's Information:

Name: _____ Professional title: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____
Signature: _____ Date: _____

Fax, email or regular-mail form to:
Disability Services
Academic Development Center
100 Ochre Point Ave., Newport, RI 02840
Fax: 401-341-2912
Email: disabilityservices@salve.edu