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

Certifying Physician or Specialist's Verification of Disability

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 the disability was first diagnosed: _____________________ By whom: ____

Disability-related diagnosis/diagnoses or results of evaluation - medical or DSM-V (please 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 disability constitute a ***current and substantial limitation*** on a major life activity (i.e. learning)? ☐ YES ☐ NO

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

____

____

Severity of symptoms: ☐ mild ☐ moderate ☐ severe

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

Treatment plan: Please include prescribed medications and potential side effects, as well as follow-up care:

____

____

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 record and may be released to the student upon his/her written request.

Certiifying Professional's Information:

Name: ____ Professional title: _____________________________________

Address: ______________________________________ City, State, Zip: ____

Phone:____ Fax: ____

Signature: _____________________________________ Date: ____

Fax or mail form to:
Disability Services
Academic Development Center
100 Ochre Point Ave., Newport, RI 02840
Fax: 401-341-2912