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 condition 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, medical or disability-related evaluation (***not*** a 504 Plan or IEP):_____________________

Does the condition constitute a *current and substantial limitation* of a major life activity? **YES** ☐ **NO** ☐

Briefly describe the nature of the functional 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, *frequency of treatment,* any specific condition management plans, as well as prescribed medications and their potential side effects:

____

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Schedule for re-evaluation, if needed: __________________________________

What general supports will this student likely need to have *a fair and equal opportunity* to learn and live in college relative to same-aged, non-disabled college peers? *(e.g. extended time for test-taking, etc.)* ***and*** briefly explain the nexus between the accommodation and the student's disability.
Please note that specific accommodations are determined by the University on the basis of documentation and clinical interview:

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

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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. I also agree to be contacted if necessary for additional information.

____ ______________________
Signature ***Date***

Certifying Professional's Information:

Name: ______________________________ Professional title: ______________________________

Address: ______________________________ City, State, Zip: ______________________________

Phone:______________________________ Fax: ______________________________

Signature: ______________________________ Date: ______________________________

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