UNIVERSITY OF MARYLAND GLOBAL CAMPUS

DISABILITY VERIFICATION FORM FOR STUDENTS WITH PHYSICAL AND/OR CHRONIC MEDICAL DISABILITY

Accessibility Services

3501 University Boulevard, East Largo, Suite 2441, Adelphi, MD 20783

Main line: 240-684-2287 Fax: 240-684-2590

To be completed by diagnosing physician:

The following student _____has asked to register with Accessibility Services (AS) at University of Maryland Global Campus (UMGC). AS requires documentation of the student's disability in order to establish eligibility and provide appropriate services.

Under the Americans with Disabilities Act (ADA) 1990 and Section 504 of the Rehabilitation Act of 1973, students are protected from discrimination and may be entitled to reasonable accommodations. In compliance with the requirements set forth, this form is to verify that a disability exists and accompanying the disability are functional limitations. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and/ or services.

The information you provide will not become a part of the student's academic records, but will be kept confidential, and placed into the student's file at AS. Indicated by the signature below, the student has given permission to release information to UMGC.

Signature of student _____ **Date** _____

After completing this form, please mail or fax the form to the address above. If you have any questions regarding the nature of the information requested on this form, please feel free to contact Accessibility Services at (240)684-2287 or accessibilityservices@umgc.edu. Thank you for your assistance.

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1. **Please describe the student's physical or chronic medical disability:**

2. **Level of severity (circle one): mild moderate severe**

Date of diagnosis: _____ Date of last visit: _____

Approximate date of onset of symptoms: _____

3. **Describe symptoms that meet the criteria for this diagnosis (also attach diagnostic report):**

4. **Is the student currently on medication? _____ List all the current medications prescribed. Please include possible side effects that impact academic performance and attendance.**

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5. Major Life Activities Assessment: Please indicate the disability's impact, if any, on the activities listed below, and describe the impact if appropriate.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't KNOW	Please describe if moderate or severe impact
Walking (e.g. how far/long can student walk, use mobility devices such as wheelchair, etc.)	☐	☐	☐	☐	
Standing (e.g., duration)	☐	☐	☐	☐	
Sitting (e.g., duration)	☐	☐	☐	☐	
Performing manual tasks (e.g., reaching, manipulating materials & lab equipment, etc.)	☐	☐	☐	☐	
Writing/Keyboarding (e.g., unable to keyboard more than 10min, unable to handwrite, etc.)	☐	☐	☐	☐	
Speech impairment	☐	☐	☐	☐	
Breathing	☐	☐	☐	☐	
Sleeping	☐	☐	☐	☐	
Self care	☐	☐	☐	☐	
Hearing (or attach most recent audiogram)	☐	☐	☐	☐	
Vision (or attach most recent eye exam)	☐	☐	☐	☐	
Other (please describe):					

6. Describe the effect of the medical condition, including side effects such as chronic fatigue and/or pain symptoms, on academic performance (e.g., concentration, reading, thinking, unable to sit or write for long periods, needs frequent restroom breaks) and attendance:

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7. **Will the functional limitations last for the duration of the student's matriculation at UMGC? _____ Yes; _____ No**

8. **If functional limitations fluctuate, how frequently does the student experience flare-ups within the past 12 months or since onset of diagnosis?**

9. **If student is undergoing treatment, please describe how treatment (e.g., frequency of treatments, side effects of treatments, etc.) may affect student's academic performance and attendance.**

10. **Do you have any recommendations regarding effective academic accommodations for the student while attending UMGC?**

11. **In addition to the diagnostic report, please attach any other information relevant to this student's academic situation at UMGC (e.g., sleep studies, eye exams, audiograms, etc.).**

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CERTIFYING PROFESSIONAL:

Printed Name and Title: _____

Signature/Professional Stamp: _____

Date: _____

License Number: _____

Address: _____

_____

Telephone: _____ Fax: _____

Number of years working with adult college students: _____