UNIVERSITY OF MARYLAND GLOBAL CAMPUS

Accessibility Services
accessibilityservices@umgc.edu
www.umgc.edu/as

Accessibility Services Third-Party Verification Form

Student Information: (to be completed by student)

Student Name:_____ **Student ID:**_____

Email:_____**Phone:**_____

Student Signature_____**Date** _____

**I authorize the University of Maryland Global Campus to receive information from the provider listed below. I also authorize my provider to discuss my disability(ies) with the appropriate University personnel to make a proper determination of necessary accommodations. My signature also indicates that the appropriate healthcare provider or their designee has completed the statements and documentation. I understand that providing false information places me in violation of the University of Maryland Global Campus's Code of Student Conduct and subjects me to any applicable sanctions.*

Purpose of This Form:

At the University of Maryland Global Campus, Accessibility Services (AS) coordinates the provision of accommodations for students with diagnosed disabilities to ensure equal access and opportunity to educational programs and activities.

Documentation can aid us in the process of determining if a diagnosed condition meets the legal definition of a disability covered under the Americans with Disabilities Act of 1990 (ADA), ADA Amendments Act of 2008 (ADAA), and Section 504 of the Rehabilitation Act (1973). Additionally, an understanding of the functional limitations of the condition can help us determine appropriate reasonable accommodations for a student in the higher education setting.

The information provided will be kept in the student's AS file, where it will be held securely and confidentially. This form may be released to the student at their request.

Please note: Documentation must come from a licensed or credentialed provider or evaluator whose certification or expertise is relevant to the disability or diagnosed condition

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Health Care Provider Information:
To be completed by a licensed and/or certified professional who is an impartial evaluator and not a family member or in a dual relationship with the student.

Student's Name:_____ **DOB:**_____

Date student was first seen_____ **Date student was last seen**_____

How often do you see this student? _____

Provider Name (print) _____

Credentials and State License or Certification #:

_____

Provider Signature_____ **Date** _____

By signing above, I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Address:_____

Phone Number:_____ **Email:** _____

Instructions
Please legibly and thoroughly complete this form. The more details provided, the better we can help the student. Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

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Section 1: Verification of Disability

The Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008 define disability as a physical or mental impairment that substantially limits one or more major life activities and has an expected duration of not less than 6-8 weeks.

Please note that a diagnosis alone does not automatically qualify a student for accommodations. The information on this form should identify a disability, describe its current impact and address how the impairment substantially limits a major life activity.

1. Is the student's condition, as they currently experience it, classified as a disability?

   ☐ Yes ☐ No (If no, there is no need to continue further with this form)

2. Diagnosis(es) _____

   _____

3. Please describe the current symptoms of the condition, including the frequency, severity, and pervasiveness of these impacts?

   _____

   _____

   _____

   _____

   a. If the student has episodic flare-ups, please also detail the triggers and the typical frequency and duration of these episodes.

      _____

      _____

      _____

      _____

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4. Please describe how the limitations impact the student's daily major life activities:

   a. In the academic environment, if applicable (e.g., difficulty hearing lectures or class discussions, concentration problems while testing or in classroom settings, difficulties interacting in group projects or discussions).

_____

_____

_____

_____

   b. In the online learning environment, if different from the information provided above (e.g., using a mouse or keyboard, sensitivity to computer monitor use, understanding written instructions).

_____

_____

_____

_____

5. Have there been any significant life events that have impacted the student's ability to learn and/or complete major life activities in the past 12 months?

   ☐ No ☐ Yes (If yes, please explain)

_____

_____

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Section 2: Expected Duration of Condition

- ☐ Permanent, continuous: Symptoms and functional limitations are expected to endure throughout their academic tenure with little likelihood of change.
- ☐ Permanent, episodic: Cycles of wellness interrupted by episodes of sickness or impairment throughout their academic tenure.
- ☐ Temporary, Functional limitations are temporary, or the severity may change, and should be reassessed by:_____/_____/_____
- ☐ Provisional: I am still monitoring/assessing the student. Assessment likely to be completed by:____/_____/_____

Section 3: Current Treatment

1. (Select): ☐ Individual/Group Therapy ☐ Physical Therapy

   ☐ Occupational Therapy ☐Medication Management

   ☐ Other: _____

2. Is the student currently taking medications?

   a. ☐ Yes ☐ No ☐ N/A – not prescribing physician

      i. If yes, please describe how the medication impacts the student's ability to participate in the educational process or in daily living activities.

_____

_____

_____

3. Does the student utilize any tools or assistive technology to assist with mitigating the symptoms or functional limitations identified? If so, please list.

_____

_____

_____

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Section 4: Academic Accommodations (if applicable)
Accommodations at the college level are intended to provide access rather than ensure success. Accommodations cannot fundamentally change a program or course's essential requirements. AS may find that the recommended accommodation is not appropriate and propose a reasonable alternative.

1. What academic accommodations would you support and why?

_____

_____

_____

_____

2. Is there any additional information we should be aware of regarding the student's disability and how it might impact their academic and social functioning within a college setting?

_____

_____

_____

_____

How to Submit
Once this form has been completed it should be submitted to AS. The student can upload this form with their application, or it can be turned into AS directly by either the student or healthcare provider via the following link:
https://amacsam.quickbase.com/db/bqu5vvyj5?a=nwr

Or to our email address accessibilityservices@umgc.edu