DISABILITY VERIFICATION FORM (Form 1)
Medical Provider Verification

Dear Health Care Professional,

One of your patients is a student at Siena Heights University requesting a disability-based academic accommodation. Accommodations are made for qualified students with a disability in order for them to equally participate in all programs and services offered by the College to ensure compliance with all applicable disability laws. In order for the Office of Accessibility to determine the student's accommodation eligibility, we need your clinical assessment/diagnosis of the student. You may fax a copy, but our records must include your signature and business card, or you may provide official letterhead.

In order for the student to be certified as eligible, the documentation must show how the disability substantially limits one or more major life activities. Current and relevant information is required in order to determine the appropriate reasonable accommodation that may be offered to the student.

All information should be completed by a medical provider qualified to diagnose and treat the student's disability.

Please provide the following:

(a) A completed and signed Provider Verification packet for each disability and (b) Your business card stapled to each Provider Verification packet.

The information you provide will be kept confidential in accordance to the Family Education Rights and Privacy Act (FERPA) and may be released to the student upon written request for records.

If you have any questions regarding this form or opportunities for the student, please contact Office of Accessibility at the information listed below. We may also contact you directly for supplemental information if necessary to make a determination

Thank you for your assistance,

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*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, **we are asking that you not provide any genetic information when responding to this request for medical information**. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought of received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider Verification of Physical/Medical Disability

Student Name: _____ Student ID: _____

To the Student: **The form below the line must be completed by your medical provider** who is qualified to diagnose and treat your disability. Office of Accessibility (OA) reserves the right to request additional documentation or contact your provider for additional information. If this form is completed by anyone other than a qualified licensed profession, the information will not be used to support your accommodation request. Inaccurate and incomplete documentation may hinder the College's ability to accommodate you based on its policies and procedures.

Please sign the box below to give your medical provider authorization to release information to OA.

I, _____, authorize my medical provider to release to Siena
Printed Student Name

Heights University's Office of Accessibility the medical information requested on this form for the purpose of determining appropriate accommodations for my disability while a student at Siena Heights University.

Patient Signature: _____ Date: _____
Student Signature

TO BE COMPLETED BY MEDICAL PROVIDER

Is the student currently under your care? ☐ No ☐ Yes If yes, for how long? _____

_____

What is the diagnosis/impairment/condition? (Please describe and use ICD 10 diagnostic codes and or APA DSM 5)

_____

_____

_____

_____

_____

Date(s) of Onset: _____

A. FUNCTIONAL LIMITATION CHART

Reminder: Please identify functional limitations without regard for mitigating measures (i.e., medications). For intermittent conditions, assess functional limitations based on a picture when all symptoms are active. Use an "X" to indicate level of impact on major life activities.

Major Life Activities	**No Impact**	**Moderately Impacts**	**Substantially Impacts**	**Unknown**
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Sitting				
Other:				

What are the specific functional limitations resulting from the disability's impact on the major life activities in a learning environment (e.g. unable to handle stairs, miss class due to side effects from disability or medication, unable to sit for long periods of time)? _____

_____

_____

Are the functional limitations permanent? ☐ No ☐ Yes If no, what is the anticipated date of resolution? _____

_____

Is the student currently undergoing treatment? ☐ No ☐ Yes If yes, please describe the type of treatment and list any medications and possible side effects that may affect the student in an academic setting: _____

_____

_____

_____

B. FUNCTIONAL OR BEHAVIORAL PRESENTATION CHART

Please use an "X" to indicate additional limitations or behavioral manifestations.

Limitations and Behavioral Manifestations	**Not an Issue**	**Moderate Issue**	**Substantial Issue**	**Unknown**
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

What are the specific behavioral limitations resulting from the disability's impact on the major life activities in a learning environment? _____

_____

_____

Are the behavioral limitations permanent? ☐ No ☐ Yes If no, what is the anticipated date of resolution? _____

_____

Is the student currently undergoing treatment? ☐ No ☐ Yes If yes, please describe the type of treatment and list any medications and possible side effects that may affect the student in an academic setting: _____

_____

_____

_____

Medical Provider Information:

First Name: _____ Last Name: _____

Title: _____ State License Number: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Fax: _____

Physician/Provider Signature: _____ Date: _____

PLEASE ATTACH
BUSINESS CARD
HERE

PLEASE RETURN COMPLETED FORM TO:

Julia Cassell
Director of Accessibility
jcassell@sienaheights.edu

Tel: 517-264-7651
Fax: 833-413-2849

Siena Heights University
1247 East Siena Heights Drive
Ledwidge Hall #160
Adrian, MI 49221

STUDENT INFORMATION & DISABILITY ACCOMMODATION REQUEST (Form 2)

Accommodations Requests also include requests for Auxiliary Aids and Services **Student Information:**

Name:_____

Student ID:_____ Date of Birth: _____

Address: _____

Primary telephone: _____ Email: _____ Do you give permission to leave confidential information on voicemail? Y __ N __ Would you like to receive email updates and reminders from our office? Y __ N __

Emergency Contact Information (optional):

Date_____

Semester _____

Year _____

_____

_ Are you currently enrolled at Siena Heights University? Y __ N __ If yes, check campus:

Adrian
Battle Creek
Benton Harbor
Dearborn
Diocese of Lansing
Jackson
Kalamazoo
Lansing
Metro Detroit
Monroe
Online Learning Program

If no, when will you enroll and where? _____

Career Goal or Major: _____

Disability Information:

What is your disability or disabilities? _____

_____

Check All That Apply:

Learning Disability
Asperger's/Autism
Deaf/Hard of Hearing
Mental Health
Blind/Low Vision
Traumatic Brain Injury
Physical/Mobility
Other _____
_____
_____

What accommodations will assist you in your academic life? _____

_____

Check all support you receive and list corresponding contact information:

MRS (Michigan Rehabilitative Services)
BSBP (Bureau of Services for Blind Persons)
CMH (Mental Health Services)
OTHER _____

Agency Name: _____
Contact Name: _____
Telephone: _____
Agency Name: _____
Contact Name: _____
Telephone: _____

STUDENT AGREEMENT REGARDING DISABILITY ACCOMMODATION REQUESTS

Please read carefully and initial each statement below indicating your agreement:

_____I understand that I must submit a request for accommodation and provide requested documentation of my disability to Office of Accessibility in order to be eligible to receive accommodation(s).

_____I understand that accommodation requests with approved documentation may take 2-4 weeks to be processed and, if possible, implemented by the University.

_____I understand that, for Office of Accessibility to provide effective accommodation(s) for me, information related to my enrollment, courses, and disability will be used by Office of Accessibility for purposes of preparing or providing reasonable accommodation.

_____I consent to the University's Office of Accessibility to communicate regarding my disability as it pertains to my accommodations, educational needs, and progress.

_____I understand that, in order to receive timely accommodations, I will be responsbile to commuunicate with my instructors regarding proposed or approved accommodation(s), my educational needs, and progress reports as needed, via the Letter of Accommodation provided by the Office of Accessibility. Unless specifically requested in writing, the Office of Accessibility will not communicate my disability outside of Office of Accessibility.

_____ _____

Student Signature Date

For Office Use Only:

Did student provide and attach requested documentation to be eligible for accommodation? Y ____ N _____
If no, was student provided with a Disability Verification Form and reminded of his or her responsibility to obtain said documentation prior to being eligible for accommodation? Y____ N____

Did Disability Services provider and student discuss the student's class schedule and specify which courses he or she desired accommodation(s) for? Y____ N____

OA Provider: _____ Date: _____

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