Office of Academic Development

Disability Support Services – Knight Hall

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Verification of Physical, Psychological, or other Medically-related Disability (Housing)

To ensure the provision of reasonable and appropriate services and/or accommodations for students with disabilities at Arcadia University, a healthcare provider who is qualified to diagnose the disability must provide current and comprehensive documentation of the student's disability.

For those students with **SINGLE ROOM REQUESTS**; AU requires documentation that justifies the medical necessity of a single room. Examples of medical necessity may include: presence of 24/7 personal care attendant, self-catheterization, need to store a power chair, significant mental health disorders, etc. While it may not be a medical necessity to a have a single room, students with disabilities may be given a single room preference due to their disability when available and will be charged the single room rate.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation from a *licensed qualified professional* must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations.

So that we may better evaluate the request for this accommodation, please answer the following questions:

Student's Name:____________________________________Today's Date: ______________________

Date of Diagnosis:________________________Date Student was Last Seen: __________________

Is the patient/ student currently under your care regarding this diagnosis? ______________________

ICD or DSM-V diagnosis(es):

In addition to diagnostic criteria, PLEASE tell us how you arrived at your diagnosis?

Arcadia University collects, maintains and shares the information needed to deliver our educational and study abroad services, and/or manage employer responsibilities, and to meet accreditation, regulatory, and statutory requirements. The full policy is available: http://live-arcadiaedu.pantheonsite.io/sites/default/files/Notice_of_Privacy_Policy_-_President_Signed_July_13_2018.pdf

Please describe the present symptoms of this condition.

What instruments/procedures were used to diagnose the condition? (Structured or unstructured interviews with the student, interviews with other persons, behavioral observations, developmental history, educational history, medical history, social history, neuro-psychological testing, psycho-educational testing, standardized or unstandardized rating scales) Please attach diagnostic reports if available.

Is this student currently taking medication for this condition? (Please Circle.) **Yes** **No**

If yes, please list the medications and dosages:

Date that medications were first prescribed: ______________________________

Please describe (briefly) the effects of these medications. How might side-effects, if any, affect this student's academic performance?

If the student is currently undergoing treatment, please describe the treatment and how treatment may affect the student in a post-secondary setting.

Life Activity – Functional Limitations

Please check all of the major life activities listed below that are affected because of the disability. Please indicate the level of limitation.

Concentrating

☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Memory

☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Sleeping

☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Eating
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Interacting with Others
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Self-Care
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Managing internal distractions
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Managing external distractions
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Attending class regularly and on time
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Stress Management
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Organization
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Bodily Functions (Please Specify): ______________________________
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Other (Please Specify):______________________________
☐ No Impact ☐ Minimal Impact ☐ Moderate Impact ☐ Substantial Impact ☐ Uncertain

Please describe any additional functional limitations resulting from the impact of this disability on the student's academic performance.

Please describe the impact of this disability on the student's non-academic life (e.g. housing or other aspects of student life).

Are the functional limitations permanent? (Please Circle.) **Yes** **No**

If not, what is the student's prognosis? How long do you anticipate that the student's academic achievement will be impacted by his/her disability? (Please check one.)

☐ 6 Months ☐ 1 Year ☐ More than 1 year

Are the functional limitations degenerative? (Please Circle.) **Yes** **No**

If so, what significant consequences might impact the student in a post-secondary setting?

Please describe or attach any additional information that you believe to be relevant to the student's disability-related academic needs.

CERTIFYING PROFESSIONAL*

All contact information and documentation is kept in a separate, private file within the Office of Academic Development, Disability Support Services. This form may be released to the student at his or her request. No information about accommodations or documentation will be released or discussed without written consent from the student.

Signature:____

Printed Name and Title: ________________________________

License Number: ___________________________________

Address: ____

Date:____________Telephone:____________________Fax: ________________

** Qualified diagnosing professionals are licensed and follow established practices in the field (e.g. specialist). Professional licensure information of the provider, including state(s) where the provider is licensed must be provided. Please note that Pennsylvania law requires that practitioners be licensed in this state in order to treat PA residents. For the purposes of this documentation, practitioners must be licensed either in Pennsylvania, in the student's home state, or state the treatment is occurring.*

If you have any questions, please feel free to call. **When completed, please return this form to:**

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