ARKANSAS COLLEGES OF HEALTH EDUCATION

Student Verification of Disability Form

Student Name:_____ Birth Date:_____

I, _____, authorize the release of necessary confidential medical information regarding my disability. I am requesting disability accommodations through the Office of Academic Affairs at Arkansas Colleges of Health Education (ACHE). The school requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability-related accommodations. Please respond to the following questions as soon as possible and return to me or send to the disability office by mail or fax. I authorize the Office of Academic Affairs to contact you if clarification is needed.

Student Signature:_____ Date:_____

Healthcare provider name (print):_____

Title:_____ Phone:_____ Fax:_____

Organization and address:_____

_____

The following area must be completed by the healthcare professional listed on this page. Page 4 may be utilized if additional space is required.

1. Diagnosis(es) and date(s):

   _____

   _____

   _____

2. Current status of condition(s) (e.g., active, progressing, controlled, in remission):

   _____

   _____

3. Current level of severity (circle one): Mild Moderate Severe

4. How long is this condition(s) likely to persist (be as specific as possible—e.g., lifetime; 1 academic year; duration of academic program enrollment; 1 month; temporary):

   _____

5. Please list procedures/assessments used to diagnose this student's condition:

_____

_____

_____

6. What are the functional limitations or symptoms of the condition(s)?

_____

_____

_____

Additionally, what major life activity(s) (includes major bodily functions) is/are affected?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Other: (describe)
☐ Breathing	☐ Interacting with Others	☐ Reading	☐ Standing	
☐ Caring for Self	☐ Learning	☐ Seeing	☐ Thinking	
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping		

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

7. What exacerbates this student's specific disability(ies)? (Please be as specific and detailed as possible)

_____

_____

_____

8. How does the condition (and/or current treatment) impact the student's ability to learn or meet the demands of the university setting and/or clinical requirements?

_____

_____

_____

_____

9. Identify any accommodations you believe may be necessary in order for the student to participate in the university's programs, activities, and services:

_____

_____

_____

_____

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified healthcare provider.

Providers name (Please print): _____

Professional license or specialty: _____

_____
Signature

_____
Date

Physician/Clinic Stamp or Seal
Signature required, in no stamp available

Thank you for your cooperation. You may email your report to the Office of Academic Affairs at studentaccommodations@achehealth.edu. Please call 479-308-2300 if you require additional information. Please attach any additional reports or relevant information. All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).