Harris Family cdhp Center for Disability and Health Policy

Disability Verification Form

In order for HFCDHP to provide disability-related services, our staff needs to establish that the individual listed below has a physical or mental impairment that limits one or more of the major life activities and the impact on essential functions. Please complete the form fully.

TO BE FILLED BY INDIVIDUAL:

Today's Date: _____

Individual's Name: _____ College: _____ Grad Yr.: _____

Signature: _____ Date: _____

TO BE FILLED BY HEALTH CARE PROVIDER: Note: Must have expertise in the differential diagnosis of the documented disorder or condition, follow established best practices in the field, and not be related to the patient.

Diagnosis: Please state the diagnosis including DSM codes. Additional information required for LD.

_____

_____

How did you arrive at your diagnosis? Check all that apply:

- ☐ Structured/Unstructured Interviews
- ☐ Interviews with Other Persons
- ☐ Behavioral Observations
- ☐ Medical Tests
- ☐ Medical History
- ☐ Developmental History
- ☐ Psychoeducational Testing

History and Prognosis:

Date condition(s) first diagnosed: _____

Date most recently seen: _____

Times individual is seen: _____

- ☐ Temporary
- ☐ Permanent

Severity: ☐ Mild ☐ Moderate ☐ Severe

Condition: ☐ Stable ☐ Improving ☐ Worsening ☐ Cyclically Variable

Prognosis: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

309 E. Second Street, Bldg. 390, Pomona, CA 91766
disabilityaccommodations@westernu.edu ● 909-469-5441

Western University OF HEALTH SCIENCES

Medications: If the individual is taking any medications, please list them below and describe side effects and any impact on performance. Note if limitations/symptoms persist even with medication.

Medication and Dosage	Side Effects	Academic/Work Impact	Persistence of Symptoms

Please list which specific symptoms currently manifesting themselves might effect the individual's ability to do essential functions.

Please list the areas the individual is functionally limited in because of the medical diagnosis and/or the medication. Please indicate the level of limitation.

Does the impairment substantially limit the operation of a major bodily function? If so, please describe what bodily functions are affected.

Have there been any changes in the individual's condition in the past 12 months or do you anticipate any changes in the next 12 months? Please explain.

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

Please list any specific accommodations or services to address the functional limitations identified above.

Is the individual working with another physician or specialist to treat the condition(s)? Please explain.

Please list anything else that should be known about the individual's medical condition. You may attach any additional documentation for the condition. For Learning Disabilities, please attach assessment scores.

PLEASE TYPE OR PRINT CLEARLY

Name and Title _____

Signature _____ Date _____

License/Certification # _____ State _____

Address _____

City, State, Zip Code _____

Phone _____ Fax _____

Students: Please return this form and additional documentation to the Harris Family Center for Disability and Health Policy (^{HF}CDHP) at disabilityaccommodations@westernu.edu or fax ro 909-469-5503.