



Southeast Arkansas College
Office of Disability Services
1900 Hazel
Pine Bluff, Arkansas 71603
Phone 870-543-5949 Fax: 870-373-5107

Medical Disability/Chronic Health Verification Form

The Office of Disability Services (ODS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Title II of the Americans with Disabilities Act (ADA) OF 1990. The ADA defines a disability as a physical or mental impairment has substantially limits one or more major life activities. "Major life activities" include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, and working, as well as mental and emotional processes such as thinking, concentrating, and interacting with others. For a student to be considered eligible to receive academic accommodations, the documentation must show the functional limitations that impact the individual in the academic setting.

The ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Southeast Arkansas College (SEARK) generally requires documentation prepared within the last three (3) years. SEARK reserves the right to request updated or more extensive evaluation. The outline below has been developed to assist the student working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified practitioner. These persons are generally trained, certified or licensed family physicians, orthopedists, neurologists, endocrinologists, cardiologists, psychologists, psychiatrists, or members of a medical specialty.
- All parts of the form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional, related information. If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.
- **After completing this form, sign it, complete the healthcare provider information section on the last page and mail or fax it to us at the address provided on this form..** The information that you provide will NOT become part of the student's educational record, but it will be kept with the student's file at ODS, where it will be held strictly confidential.

STUDENT INFORMATION

First name _____ Middle _____ Last _____

Date of birth _____ Last four digits of SSN _____

Status (Check one) current student transfer student prospective student

Cell phone (____) _____ - _____ Local phone (____) _____ - _____

Address _____

Diagnostic Information

Please provide the following information:

1. Date of Diagnosis _____

2. Date of Last Contact with Student: _____

3. Is the student currently receiving therapy or counselling?

Yes No

4. What is the severity of the condition? Please check one:

Mild Moderate Severe

Explain severity:

5. Describe the symptoms associated with this medical condition?

6. What is the expected duration of this disability?

7. List the **current medication(s) dosages, frequency, and possible adverse side effects** as related to academic performance.

8. List **any other treatment** that the student is receiving to manage his/her condition:

9. Describe how this medical condition **substantially limits a major life activity and how it may impact the student's progress** in an academic setting:

10. List **any recommendations for accommodations** that you have for this student in an academic setting:

Health Care Provider's Signature Information

Print, sign, and date below and fill in the other fields completely. *Please print or type*

Provider's name(Print) _____

Provider's signature: _____ Date _____

Title: _____

License or Certification # _____

Address:

Phone number (____) _____ - _____

Fax number (____) _____ - _____