

WILSON COLLEGE

Disability Verification Form

To Be Completed by Student's Health Care Provider.

Student Information:

Name: _____

Home Address: _____

City/State/Zip: _____ Cell Phone (____) _____ - _____

Care Provider Information:

Provider Name: _____

Credentials/Licensing: _____

Provider Practice Name and Address:

Office Phone Number: _____

Office Email: _____

The student named above has requested accommodations from Wilson College because of a disability. A disability is defined under the Americans with Disabilities Act as a "physical or mental impairment that substantially limits one or more major life activities."

1. Please cite the student's disability(ies)/diagnosis or impairment:

2. Date of diagnosis: _____ Made by you? _____

- a. If not, by whom? _____

3. Number of consultations in the past 3 years: _____

4. Positive and adverse side effects of any prescribed medications:

5. Date of most recent evaluation: _____

6. Length of time under your care: _____ Currently under your care? _____

- a. If no longer under your care, when did care end? _____

7. Please describe in detail the type, severity and frequency of symptoms currently experienced by the student, and how it substantially limits one or more major life activities. (Please use additional pages if needed.)

8. Please describe and provide rationale for any accommodations that you recommend addressing the student's disability. Please explain how the modification you recommend would address the functional limitations of the student's condition. (Again, please use additional pages if needed.)

Documentation for eligibility must reflect the current functional impact the disability has on the student's learning or other major life activities and the degree to which it affects the individual in the context (dining, learning, residential, etc.) for which the accommodation(s) is(are) requested.

A connection must be established between the requested accommodation and the functional limitations on the student in the college environment (learning, residential, etc.).

Please sign and date this questionnaire

Provider Signature _____ Date _____

Care providers should send the disability documentation directly to the Accessibility Services Coordinator in one of the following ways:

Email: Sarah.Feldberg@wilson.edu Mail: Accessibility Services Coordinator
Fax: (717) 262-4845 Academic Support Center
1015 Philadelphia Ave
Chambersburg, PA 17201