Accessibility Services: Documentation Requirements & Verification Form

Southern California University of Health Sciences is committed to ensuring equal access to educational opportunities for students with disabilities. To provide this access, Student Services facilitates academic accommodations for regularly enrolled, matriculating students and Accelerated Science course takers with disabilities.

Eligibility

In addition to the student's declaration of disability and need for accommodation, Student Services requires current and complete documentation from the student's diagnosing, treating clinician. Qualified clinicians are licensed, non- familial, follow established practices in the field, and are most often physicians, licensed psychologists, psychiatrists, social workers, or licensed therapists. For clinical assessments, the professional conducting the assessments and rendering diagnoses must have comprehensive training about the specific disability being addressed.

Documentation must describe how the disability limits one or more major life activities and to what extent the student experiences disability-related, academic limitations. It should also be written within a reasonable timeframe relative to the disability. If your medical provider is submitting a letter in lieu of the attached verification form, it should contain ALL the following information:

1. Student's name, ID number, and date of birth
2. Name, Title, Licensing State(s) and Number, Address, Area of Specialization, and Signature of qualifying, diagnosing clinician
3. Medical/clinical diagnosis as listed in the DSM-5 or ICD-10
4. Explanation and/or basis for diagnosis (tests, clinical interview, observations, history)
5. Onset of condition, date clinician first treated student, most recent visit, expected duration of disability, and other relevant educational, developmental, and medical history
6. *Current* functional limitations
7. Statement of the extent to which limitations are mitigated by treatment and side effects of treatment if any
8. *If making recommendations for specific accommodations:* Justification for each recommended accommodation and the direct relationship to the functional limitations must be produced.

Please note the following:

- Incomplete information may slow or delay the accommodation approval process.
- Depending on the nature of the condition, Student Services may require a comprehensive report (i.e., cognitive achievement test scores, audiogram, and/or other relevant information to determine reasonable accommodations).
- For observable/obvious disabilities, medical documentation may not be required when the accommodation requested is apparent or logical.
- We appreciate your thorough and thoughtful support letter or response to the questions on the following form. If you have questions about this form or how the information is used, we invite you to email us at studentservices@scuhs.edu

Student Name_____Student ID_____D.O.B. _____

Verification Form

Note to student: *Please do not complete this form -- it must be completed by your treating clinician.*

This request for information regarding my disability is being provided to you in connection with my application for academic support services from Student Services at Southern California University. Student Services requires current and comprehensive documentation of my disability from a qualified diagnosing professional as part of the process to determine my eligibility for reasonable and appropriate academic adjustments based on functional limitations resulting from my condition. "Qualified diagnosing professionals" include licensed clinicians whose scope of training and experience include diagnosis and treatment of adults. Please respond to the following questions as soon as possible and return to Student Services email at studentservices@scuhs.edu

Health Care Provider Information

Name:	Title:
License #:	Specialty:
Address:	
Phone:	Fax:

Medical Information – If this is your first time seeing this patient, please review the patient's records, if available, to provide the following information. The student may also have their primary care physician provide this information.

The following questions are to be answered by the qualified professional identified above. If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly. If you would like to share any related pertinent information, please do so here:

Please Note: *Depending on the nature of the condition, Student Services may require a comprehensive report (ie cognitive achievement test scores, audiogram, and/or other relevant information to determine reasonable accommodations)*

Diagnostic Information

Please list the diagnosis/es and the relevant DSM-5 or ICD-10 codes:

Please state whether you believe that the requesting person meets the definition of having a disability as defined by the ADA, as described here: https://adata.org/faq/what-definition-disability-under-ada

Yes ☐ *No* ☐ *Unsure* ☐

Severity of the diagnosis/es: *Mild* ☐ *Moderate* ☐ *Severe* ☐

Nature of the diagnosis/es: *Acute* ☐ *Episodic* ☐ *Chronic* ☐ *In Remission* ☐

Prognosis: How long do you anticipate this student's academic performance will be impaired by her/his disability?

How was this diagnosis determined (neuropsychological or psychoeducational testing, behavioral observations, structured interview, collateral information, rating scales, developmental/medical history)? *(Please attach/scan diagnostic report of assessment(s) if available)*

What historic data was considered in making the diagnosis? Please describe any pertinent history about this student/client:

Contact with student:

1. Onset of condition: _____
2. Date of first contact with student (mm/dd/yyyy): _____
3. Date of most recent contact with student (mm/dd/yyyy): _____
4. Please describe the frequency of your contact with this student/client (# of therapy sessions, if applicable): _____

Description of Functional Limitations: *This section must be completed by the medical provider. Failure to do so will result in an incomplete application for the student. A* ***functional limitation*** *is a restriction in the ability to perform an action or activity in the manner or within the range considered 'normal' and which is attributable to impairment.*

☐ **No functional limitations identified at this time.**

Major Life Activity	**None**	**Mild**	**Moderate**	**Severe**	***Please include explanation of limitations if moderate or severe impact is indicated. Include limitations related to medication side effects.***
Thinking/Concentrating					
Information Processing					
Memory					
Sustained Reading					
Sustained Writing					
Sustained Focus					
Executive Functioning					
Communicating					
Seeing					
Hearing					
Listening					
Learning					
Walking, Standing, or Bending					
Sitting					
Sleeping					
Eating					
Reaching or Lifting					
Immune System Functions					
Self-care					
Speaking					
Course Engagement					
Bladder/Digestive					
Respiratory/Breathing					
Other					
Other					
Other					

Accommodation Information

A diagnosis does not, in and of itself, qualify a student for accommodations under the Americans with Disabilities Act Amendments Act (ADAAA). Accommodations are not based on the student's diagnosis, but instead are designed to address the barrier(s) caused by any functional limitation(s) related to the condition. Reasonable **accommodations** are modifications or adjustments to the policies, environment, practices and/or procedures that enable individuals with disabilities to have an equal opportunity to participate in an academic program; they are not designed to guarantee student success.

Please indicate your recommendations for accommodations within the post-secondary environment, as supported by the reported functional limitations and their impact on this student.

Accommodation:

Rationale:

Accommodation:

Rationale:

Accommodation:

Rationale:

If you feel that you are unable to recommend any specific accommodations as requested above, please explain why:

Thank you for your cooperation. You can scan this completed document to studentservices@scuhs.edu. Please attach any additional reports.

*Clinical/Medical Provider's Signature:*_____ *Date:* _____