

# Medical Disability Verification



## Disability Resource Center

Disability Resource Center\*One Washington Square\*San José, CA 95192-0168

Voice: 408.924.6000\*TTY: 408.924.5990

To Evaluator:

To qualify for support services from the Disability Resource Center at San José State University, an individual must have his/her disability verified by an appropriate licensed professional. Documentation necessary to substantiate the diagnosis must be comprehensive and be based on a comprehensive diagnostic/clinical evaluation.

**Verification is requested for:**

Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Duration of Diagnosis:

Specify Dates: \_\_\_\_\_

**Description of current functional limitations in the academic environment as well as across other settings.** Explanation of how the medical condition impedes performance (e.g. reading, writing, walking, speaking, seeing, and abstract reasoning).

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**Specific information regarding any prescribed medications:**

Medication(s) prescribed \_\_\_\_\_

Quantity or dosage \_\_\_\_\_

Anticipated side effects which impact the individual in an academic setting

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Relevant information regarding current treatment *OR* a copy of the treatment plan if appropriate

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**Specific request for accommodations with accompanying rationale.** The evaluator must describe the current impact of the diagnosed medical condition on a specific life activity as well as the degree of impact on the individual. A relationship must be established between the requested accommodations and the functional limitations of the individual that are relevant to the academic setting. (e.g., The patient experiences fatigue and a loss of concentration as a result of Chronic Fatigue Syndrome which impacts the patients ability to take tests under standard conditions or focus for an extended period of time; or patient possibly diagnosed with a Herniated Disc experience continual back pain which affects the ability to walk for long distances.)

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**Certifying Licensed Physician or Primary Health Care Provider qualified in the appropriate specialty area.**

Name (Type or Print): \_\_\_\_\_ Phone: \_\_\_\_\_  
Last, First M.I.

Medical Facility \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

License #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



*For general questions pertaining to this form, or to obtain clarification about the information requested, please contact a DRC counselor at 924-6000.*