First for Women
WESLEYAN

Dear Health Care Provider:

One of your patients is requesting an accommodation at Wesleyan College due to a disability. Disability Resources will review the medical information you provide and make a recommendation for appropriate services and accommodations in order for the student to equally participate in all programs and services at the college ensuring compliance with Section 504 of the Rehabilitation Act of 1973 and The Americans with Disabilities Act Amendments Act of 2008 (ADAAA).

In order for a student to be considered eligible to receive an accommodation, the documentation must show how the disability substantially limits one or more major life activities. **All information should be completed by a qualified health care professional.** Current and comprehensive information is required in order to determine appropriate services and accommodations. Accommodations that fundamentally alter the nature of the program, lower or waive essential academic requirements or result in undue financial or administrative burdens will not be granted.

1. All parts of the Disability Verification Form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. The health care provider should attach any reports which provide additional related information.

2. Please complete a Disability Verification Form for each diagnosis to ensure consideration of all aspects of a student's needs.

3. After completing and signing the Disability Verification Form, please fax or mail to Disability Resources at the address listed on the form. The information you provide will be kept confidential in accordance to the Family Educational Rights and Privacy Act (FERPA) and may be released to the student upon her written request.

4. Documentation for the request of services may take time to process and should be provided as soon as possible.

If you have questions regarding this form or opportunities for your patient, please contact Disability Resources at the information listed below.

Thank you for your assistance!

Jill Amos, MS
Director of Disabilities and Advocacy Services
jamos@wesleyancollege.edu

Disability Resources Wesleyan College
C/O Jill Amos
4760 Forsyth Road * Macon, GA 31210
Phone (478) 757-5219 * Fax (478) 757-2430

Wesleyan College Disability Verification Form

Please return form to: Wesleyan College – Disability Resources C/O Jill Amos
4760 Forsyth Road * Macon * GA 31210 - Phone (478)757-5219 * Fax (478)757-2430

THIS SECTION MUST BE COMPLETED BY THE STUDENT

____ ____________________________
Student Last Name First Name MI Date of Birth

____________________ ______________________________
Date Requested Phone #

THIS SECTION MUST BECOMPLETED BY A LICENSED PROFESSIONAL

This student may be eligible for services and accommodations at Wesleyan College. In order to provide services we must have verification of a disability diagnosis and limitations. The information you provide will be used for the sole purpose of determining eligibility for and authorization of accommodations at Wesleyan College. Please complete a Verification Form for each diagnosed disability to ensure consideration of all aspects of the student's needs.

1. Diagnosis: ____
   (If applicable, include DSM IV Code)
2. Date of Onset: ______________________ End Date or Re-Evaluation Date: __________________________
3. Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Other _________________________
4. Duration of Condition:
   ☐ Permanent/Chronic ☐ Temporary - give estimated duration ____________ ☐ Residual/Remission
5. Condition is:
   ☐ Stable ☐ Prone to exacerbations ☐ Observable ☐ Non-Observable
6. Prescribed Medication (s), Dosage and Side Effects: ____
   ____
7. Functional limitations of conditions and/or medication (i.e. the ways in which the diagnosis affects the student):
   ☐ Attention and/or Concentration ☐ Planning and/or Organization ☐ Memory
   ☐ Stamina ☐ Mobility ☐ Speaking
   ☐ Sitting ☐ Hearing – please attach audiogram ☐ Writing
   ☐ Processing Oral Materials ☐ Vision: _____________ ☐ Reading
   ☐ Processing Visual Materials Acuity: R________ L ________ ☐ Sleeping
   ☐ Other ____
8. Please list other limitations or information helpful in determining necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations in an educational setting:
   ____

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

_________________________________ ______________________________ ____________________
Signature of Verifying Licensed Professional Title/License # Date

Name (printed) ____

Address ____ Phone ______________________________