ACCOMMODATIONS VERIFICATION FORM

Note to Physician: A student has requested for Gurnick Academy to provide disability-related services. Before we can provide such services, we need to determine that this individual has a physical or mental impairment that limits one or more of the major life activities and the impact on essential functions. Supporting documentation related to the disability is required.

Student's Name:	Date of Birth:
E-Mail:	Today's Date:

Please state the complete diagnosis (include DSM-5 diagnostic code): _____

_____

How did you arrive at your diagnosis? Please check all relevant items below (documentation is required):

Structured or Unstructured interviews	□	Medical tests	□
Interviews with other persons	□	Medical History	□
Behavioral Observations	□	Developmental History	□

Which specific symptoms currently manifesting themselves might affect the individual's ability to do essential functions?

_____

_____

_____

History and Prognosis

	Month	Date	Year		Other
Date condition was first diagnosed					
Date individual first seen for the condition					
Date most recently seen for this condition					
Expected duration of condition				Permanent	
How long do you anticipate the impact	3 months	6 months	1 year	More than one year	
The condition is	stable	improving	worsening	cyclically variable	
The prognosis is	poor	fair	good	excellent	
How often is this individual seen	weekly	monthly	3-6 months	yearly	

Is the individual currently taking medication(s) for this issue? YES NO

If yes, what medications is the individual currently taking? For each medication, describe the side effects and any impact on performance. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic/Work Impact	Persistence of Symptoms

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What other treatments are being administered? _____

_____

Please list any accommodations or services to address the limitations: _____

_____

Is there anything else you think we should know about the individual's medical condition? _____

_____

_____

Please check which areas listed below the individual is functionally limited in because of the medical diagnosis and/or the medication. Please indicate the level of limitation.

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	2	3	4	5	Major Life Activities		1	2	3	4	5	Learning / Time Management
					Caring for Oneself							Memory
					Talking							Concentrating
					Hearing							Listening
					Breathing							Organization
					Seeing							Managing distractions
					Walking							Timely submission of assignments
					Standing							Attending class regularly
					Lifting/Carrying							Making and keeping appointments
					Sitting							Managing stress
					Performing Manual tasks							Reading
					Eating							Writing
					Working							Spelling
					Interacting with others							Quantitative reasoning (math)
					Sleeping							Processing Speed

PLEASE TYPE OR PRINT CLEARLY

Name/Title _____

Signature_____ Date: _____

License/Certification #_____ State _____

Address _____

City, State, Zip Code_____

Phone _____ Fax _____