Verification Form for Chronic Health Condition

The office of Disability Support Resources (DSR) strives to insure that qualified persons with chronic health conditions are accommodated, and if possible, that there accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the job or program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

This form is designed to allow us to achieve these goals. Persons who wish to receive accommodations academic due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the person’s condition, must have experience diagnosing and treating condition, and will be an impartial professional who is not related to the patient.

Information

Last Name ___________________________________   First __________________   Middle Initial _____

Date of Birth _____________   Address _____________________________________________________

City ___________________________   State ________________________________   Zip Code __________

Certifying Professional

Name ________________________________________________________________________________

Credentials __________________________________________________________________________

Address ______________________________________________________________________________

City ___________________________   State ________________________________   Zip Code __________

License/Certification number and State of Licensure ________________________________

Years of experience working with this patient ___________________________________________

Date of initial contact with patient _____________________________________________________

Date of last contact with patient _____________________________________________________

Diagnosis: __________________________________________________________________________
Date of Diagnosis ________________________________________________

Basis on which diagnosis was made ____________________________________________

Current medications including dosage and side effects ____________________________

Long term medication plan ______________________________________________________

Current compliance with medication plan _________________________________________

Prognosis for medication plan (Include likelihood of improvement or further deterioration and within what approximate time frame) __________________________________________

Planned therapeutic interventions and its nexus to the disability (i.e., psychosocial, efficacy enhancing, self-management):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Prognosis for therapeutic interventions (Include likelihood of improvement or further deterioration and within what approximate time frame)

_____________________________________________________________________________________

_____________________________________________________________________________________

Current compliance with therapeutic interventions

_____________________________________________________________________________________

_____________________________________________________________________________________

History of hospitalization

_____________________________________________________________________________________

_____________________________________________________________________________________

**Implications for Educational Success (For Students Requesting Academic Accommodations only)**

Learning abilities specific to the post-secondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc.)

_____________________________________________________________________________________

_____________________________________________________________________________________

Implications for taking exams and other classroom activities caused by the disorder or medication. Please specify which

_____________________________________________________________________________________

_____________________________________________________________________________________

Please specify necessary accommodations for academic success.

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_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
If you have any questions regarding the nature of the information needed for mental health conditions, please call Disability Support Resources at (616) 331-2490, Monday through Friday from 8:00 am to 5:00 pm Eastern Standard Time. This form should be returned to 4015 James H. Zumberge Hall, Grand Valley State University, Allendale, Michigan, 49401.

SIGNATURE OF CERTIFYING OFFICIAL  
DATE

REQUIRED

Attach Business Card Here

Or

If Submitting Electronically, Denote Your Office Web Address