



DISABILITY VERIFICATION
Medical Condition/Chronic Health Disability

Please read the following prior to completing this form:

Student Accessibility Services at Kent State University provides support services to students with diagnosed disabilities, including serious medical conditions and chronic health disabilities. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires **current, within the past 2 years, and comprehensive documentation of the disorder from their diagnosing/current licensed physician or a certified nurse practitioner.** This should include information that describes the symptoms and manifestation of the condition, medication prescribed, and recommendations for treatment.

**NOTE: Student Accessibility Services (SAS) reserves the right to make appropriate modifications to the above time frame required for current documentation when necessary.*

For additional information about SAS please visit: www.kent.edu/sas

Please provide the following information about (student name): _____

1. Diagnosis: _____

Date of Diagnosis: _____ Last contact with student: _____

Is the student/patient currently under your care? _____ YES _____ NO

2. Describe the **symptoms** associated with this medical condition: _____

3. Describe the **student/patient's prognosis** for this condition: _____

4. List **current medication(s), dosage, frequency and possible adverse side effects** as related to academic performance: _____

5. List any **other treatment** the student is receiving to manage his/her condition: _____

6. Describe how this medical condition **substantially limits a major life activity** and **how it may impact the student/patient's progress** in an academic setting: _____

7. List any **recommendations for accommodations** you have for this student/patient in an academic setting:

8. Please describe any specific concerns you may have, or other ways that we may be of further assistance to this student/patient: _____

Healthcare Provider Information

Provider Name and Title: _____

Provider Signature: _____ Date: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone: () _____ Cell Phone: () _____

*NOTE: Cell phone number will only be used in case of emergency

The information you provide in this document is maintained in the office of Student Accessibility Services at Kent State University according to the guidelines of the Family Educational Rights and Privacy Act (FERPA).

Please mail or fax this completed form to:

Student Accessibility Services • Kent State University • Ground Floor, DeWeese Center • Kent, OH 44242

Phone: (330) 672-3391 **Fax:** (330) 672-3763 **Email:** sas@kent.edu