University of Findlay
Office of Accommodation & Inclusion

Office of Accommodation and Inclusion
1000 N. Main St.
Findlay, OH 45840
419-434-5532 Phone
419-434-5748 Fax
OAI@findlay.edu

Accommodation Verification

The Office of Accommodation and Inclusion coordinates the provision of accommodations for students with diagnosed disabilities in accordance with the Americans with Disabilities Act (ADA) of 1990 as amended as well as Section 504 of the Rehabilitation Act of 1973. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or one who is regarded as having a disability. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (psychiatrist, psychologist, counselor, social worker, medical doctor, optometrist, speech-language pathologist, etc.) in obtaining the specific information to evaluate eligibility for reasonable accommodations in the higher education setting.

A. **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified, or licensed to diagnose and treat conditions. NOTE: A recommendation for an emotional support animal to reside in the residence hall with a student with a disability must be made by a licensed mental health professional such as a psychologist, counselor, social worker, or psychiatrist.

B. **All parts of the 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.

C. **The healthcare provider or student should attach any documents which provide additional related information.** (e.g. psychoeducational assessment, neuropsychological test results, an Individualize Education Program (IEP), Multifactor Evaluation (MFE), Evaluation Team Report (ETR), a 504 Plan, verification of accommodations provided by another college/university or third party entity, etc.) If a comprehensive diagnostic report is available that provides the requested information, copies of the report can be submitted for documentation in lieu of this form. In addition to the requested information, please attach any other information that would be relevant to the student's need for accommodations.

D. **The information provided will be kept in the student's file at the Office of Accommodation and Inclusion, where it will be held securely and confidentially.** This form may be released to the student at their request.

For questions regarding this form, please call the Office of Accommodation and Inclusion. Thank you.

 Adopted from the University of Toledo

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STUDENT INFORMATION - (Complete by Student)

(Please Print Legibly or Type)

Name (First, Middle, Last) ________________________________ **Preferred Name:**_____________________

Date of Birth ____ **UF ID#**______________________________

Findlay Email Address __________________________________ **Cell Phone**___________________________

Home Address ____

By signing below, I, _________________________, hereby authorize my healthcare provider to release my medical records and history, which is relevant to my education to The University of Findlay.

Patient's Signature _________________________________ **Date:** ________________________________

____

HEALTHCARE PROVIDER INFORMATION

(Please sign and date below in addition to completing all other fields)

Provider Signature ____ **Date** _________________________

Provider Name (print) ____

Title ____

License or Certification # ____

Clinic or Practice Address ____

____

____

Phone Number _____________________________ **Fax Number** ___________________________________

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DIAGNOSTIC INFORMATION – (Complete by Physician)

(Please print legibly or type)

Primary Diagnosis: ___________________________ **Date of Diagnosis**: ____________________________

Secondary Diagnosis: _________________________ **Date of Diagnosis**: ____________________________

Please list current medications or treatments along with any side effects impacting functioning:

Major Life Activities Assessment: Please check each of the following major life activities that are impacted by the disability. Indicate severity of limitations.

Life Activity	**Negligible**	**Moderate**	**Substantial**	**Not Sure**	**Life Activity**	**Negligible**	**Moderate**	**Substantial**	**Not Sure**
Concentrating					Communicating				
Memory					Standing				
Hearing					Lifting				
Social Interactions					Managing Internal/External Distractions				
Seeing					Sleeping				
Regular Class Attendance					Organization				
Speaking					Performing Manual Tasks				
Learning					Breathing				
Reading					Bending				
Thinking					Walking				

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Major Bodily Function Assessment: Please check each of the following major bodily functions that are impacted by the disability. Indicate severity of limitations.

Bodily Function	Negligible	Moderate	Substantial	Not Sure	Bodily Function	Negligible	Moderate	Substantial	Not Sure
Immune System					Normal Cell Growth				
Digestive					Bowel				
Bladder					Neurological				
Brain					Circulatory				
Respiratory					Endocrine				
Reproductive									

In addition to the major life activities and bodily functions, describe any activities that may be impacted by the disability or barriers that may be addressed in the college environment. Please include information for the residence life setting if applicable in addition to the academic setting:

Please state specific disability accommodation recommendations for this student:

Please add any additional information that would aid the determination of reasonable accommodations: