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**Disability Verification Form**

# To be completed by the individual’s physician

In order for us to provide disability-related services, we need to establish 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. This form is designed to help us make that determination. Complete documentation guidelines are available at: <https://studentaffairs.jhu.edu/disabilities/prospective-newly-admitted-students/documentation-guidelines/>

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIAGNOSIS

1) Please state the complete diagnosis (**Note: form not for use with ADD/ADHD additional info required**):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2) How did you arrive at your diagnosis? Please check all relevant items below:

Structured or Unstructured interviews □ Medical tests □

Interviews with other persons □ Medical History □

Behavioral Observations □ Developmental History □

3) Please briefly describe as appropriate the history of presenting symptoms and past functioning, duration of the disorder, relevant development, historical and familial data.

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HISTORY AND PROGRNOSIS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 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 |  |
| Anticipated return to work date |  |  |  | TBD at a later date |  |
| 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 |  |

4) 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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

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6) 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 |

7) Does the impairment substantially limit the operation of a major bodily function? NO YES

If yes, please describe what bodily functions are affected.

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8) Please list any specific accommodations or services to address the functional limitations identified above

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9) Have there been any changes in the individual’s condition in the past 12 months? NO YES Please explain.

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10) Do you anticipate any changes in the individual’s condition/medication in the next 12 months? NO YES Please explain.

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11) Is the individual working with another physician or specialist to treat the condition(s)? NO YES

Please explain.

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12) Is there anything else you think we should know about the individual’s medical condition?

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Note: The diagnosing professional must have expertise in the differential diagnosis of the documented disorder or condition, follow established best-practices in the field, and not be related to the patient.

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PLEASE TYPE OR PRINT CLEARLY

Name/Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please return form with a letter describing in full detail more information about the medical issue to JHU as quickly as possible.

**Student Disability Services**

3400 N Charles St

Garland Hall

Suite 385

Baltimore, MD 21218

**Tel:** 410-516-4720

**Fax:** 443-529-1543

[studentdisabilityservices@jhu.edu](mailto:studentdisabilityservices@jhu.edu)

12/04/17