Health Care Provider:

One of your patients is requesting an accommodation at Wesleyan College due to a disability. Wesleyan College student counseling and health services offices do not provide disability verification for accommodations or emotional support animals. Disability Resources will review the medical information you provide and make a recommendation for appropriate services and accommodations in order for the student to equally participate in all programs and services at the college ensuring compliance with Section 504 of the Rehabilitation Act of 1973 and The Americans with Disabilities Act Amendments Act of 2008 (ADAAA). A Release of Medical Information Form signed by the student is attached. This Form authorizes the release of the requested information. Resources are available with Wesleyan College Success Fund to help students who may need financial assistance. Please see the Disability Office for information.

In order for a student to be considered eligible to receive an accommodation, the documentation must show the student has a disability, how the disability substantially limits one or more major life activities, and the requested accommodation. **All information should be completed by a qualified health care professional.** Current and comprehensive information is required in order to determine appropriate services and accommodations. Accommodations that fundamentally alter the nature of the program, lower or waive essential academic requirements or result in undue financial or administrative burdens will not be granted.

1. All parts of the Disability Verification Form must be completed as thoroughly as possible. Number 8 is required in determining appropriate educational accommodations. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. The health care provider should attach any reports which provide additional related information.

2. Please complete a Disability Verification Form for each diagnosis to ensure consideration of all aspects of a student's needs.

3. After completing and signing, please scan, fax or mail to the Disability Office at the corresponding information listed below. The information you provide will be kept confidential in accordance to the Family Educational Rights and Privacy Act (FERPA) and may be released to the student upon her written request.

4. Documentation for the request of services may take time to process and should be provided as soon as possible.

If you have questions regarding this form or opportunities for your patient, please contact Disability Resources at the information listed below.

Thank you for your assistance,

Jill Amos, MS
Director of Disabilities and Advocacy Services
4760 Forsyth Road * Macon, GA 31210
Phone (478) 757-3800 * Fax (478) 757-2430
jamos@wesleyancollege.ed

Wesleyan College Disability Verification Form

Please return form to: Wesleyan College - Disability Resources

4760 Forsyth Road * Macon * GA 31210 - Phone (478)757-3800 * Fax (478)757-4027

ATTN: Jill Amos, Director of Disability and Advocacy Services

THIS SECTION MUST BE COMPLETED BY THE STUDENT

_____ _____

Student Last Name First Name MI Date of Birth

_____ _____

Date Requested Phone #

THIS SECTION MUST BECOMPLETED BY A LICENSED PROFESSIONAL

This student may be eligible for services and accommodations at Wesleyan College. In order to provide services we must have verification of a disability diagnosis and limitations. The information you provide will be used for the sole purpose of determining eligibility for and authorization of accommodations at Wesleyan College. Please complete a Verification Form for each diagnosed disability to ensure consideration of all aspects of the student's needs.

1. Diagnosis: _____
   (If applicable, include DSM IV Code)

2. Date of Onset: _____ End Date or Re-Evaluation Date: _____

3. Severity: □ Mild □ Moderate □ Severe □ Other _____

4. Duration of Condition:
   □ Permanent/Chronic □ Temporary - give estimated duration _____ □ Residual/Remission

5. Condition is:
   □ Stable □ Prone to exacerbations □ Observable □ Non-Observable

6. Prescribed Medication (s), Dosage and Side Effects: _____
   _____

7. Functional limitations of conditions and/or medication (i.e. the ways in which the diagnosis affects the student):

□ Attention and/or Concentration	□ Planning and/or Organization	□ Memory
□ Stamina	□ Mobility	□ Speaking
□ Sitting	□ Hearing - please attach audiogram	□ Writing
□ Processing Oral Materials	□ Vision: _____	□ Reading
□ Processing Visual Materials	Acuity: R_____ L _____	□ Sleeping

   □ Other _____

8. Please list accommodations required in the educational setting (Required).
   _____
   _____

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

_____ _____ _____

Signature of Verifying Licensed Professional Title/License # Date

Name (printed) _____

Address _____ Phone _____