University of Massachusetts Lowell
UMASS
Learning with Purpose

Wellness Center, University Crossing
220 Pawtucket Street, Suite 300
Lowell, Massachusetts 01854
Tel. 978.934.6800
Fax: 978.934.2032
Email: Disability@uml.edu

DISABILITY SERVICES

Medical Disability Verification Form

Student Disability Services (SDS) is committed to providing equal access and reasonable accommodations, where appropriate, for qualified disabled students as covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Amendments Act (ADAAA) of 2008. The ADAAA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the Documentation must be received in a timely manner before accommodations can begin. The law stipulates that, in a postsecondary setting, a student does not qualify for services until they have registered with the disability office and have been certified for eligibility. Retroactive accommodations are not made.

The Student Disability Services requires current and comprehensive documentation in order to determine appropriate accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing health care professional (s) in obtaining the necessary information to evaluate eligibility for academic accommodations.

a. The healthcare professional conducting the assessment and/or making the diagnosis must be qualified to do so. The persons are generally trained, certified or licensed psychologists or members of a medical specialty.

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 should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc). **If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.**

d. After completing this form, sign it, complete the Healthcare Provider Information Section on the last page and email, fax or mail to us at the above address. The information you provide will not become part of the student's educational records, but it will be kept in the student's file at SDS, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

RELEASE OF INFORMATION

I, _____ hereby authorize the release of the following information to the Office of Disabilities Services at University of Massachusetts Lowell for the purpose of determining my eligibility for educational accommodations.

_____	_____	_____
Signature	Student ID	Date

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STUDENT INFORMATION

(Please Print Legibly or Type)

Last Name: _____ First Name: _____

Date of Birth: _____ Student No. _____

Telephone No: _____ Cell No: _____

Address: _____

Diagnosis *Information*

(Please Print Legibly or Type)

1. What is the diagnosis, date of diagnosis, and last contact with the student?

_____

_____

2. Is the student/patient currently under your care? ☐ Yes ☐ No

3. List current medications, impact, and adverse side effects.

_____

_____

_____

4. If the student is currently undergoing Medical treatment, please describe how the treatment might affect the student academically.

_____

_____

_____

_____

5. Major Life Activities Assessment:

Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

Life Activities	**1-Negligible**	**2-Moderate**	**3-Substantial**
Talking	○	○	○
Hearing	○	○	○
Breathing	○	○	○
Standing	○	○	○
Caring for Oneself	○	○	○
Reaching	○	○	○
Lifting	○	○	○
Sitting	○	○	○
Walking	○	○	○
Writing	○	○	○
Performing Manual Tasks	○	○	○
Sleeping	○	○	○
Learning	○	○	○
Reading	○	○	○
Thinking	○	○	○
Concentrating	○	○	○
Memorizing	○	○	○
Interacting with Others	○	○	○
Others:	○	○	○
Others:	○	○	○

6. Describe how this medical condition may result in specific functional limitations in an academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, or unable to walk more than 50 feet without fatigue)?

_____

_____

_____

7. What is the expected duration of this disability?

_____

_____

_____

8. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

(Please sign and date below and fill in all other fields completely using PRINT or TYPE)

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____

License or Certification No.: _____

Address: _____

Phone No: _____ Fax: _____