VCU Student Accessibility and Educational Opportunity
Student Affairs

PHYSICAL/MEDICAL/SENSORY DISABILITY VERIFICATION FORM

907 Floyd Avenue, Suite 018
Richmond, VA 23284
Phone: (804) 828-2253
Email: saeo@vcu.edu
Website: www.saeo.vcu.edu

1. IDENTIFYING INFORMATION

Student's Name _____ **V Number** _____

_____@vcu.edu **Student's Email**

Student's Phone _____

2. TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

A. Diagnostic Information

A1. Please state the complete diagnosis (ICD-10 and/or DSM-V)**:** _____

_____

A2. Date of Diagnosis: _____

A3. In addition to the DSM-V and/or ICD-10 criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student:

√	Criteria	Notes (please add information to a checked area)
	Structured or unstructured interviews	
	Interviews with other persons	
	Medical tests	
	Medical history	
	Behavioral observations	
	Developmental history	
	Psychological testing	
	Other (please specify)	

B. Contact History

B1. This student has been under a provider's care for this issue since: _____

B2. Date student was last seen: _____

C. Impact of Condition

C1. How long is this condition likely to persist? (Permanent/Temporary)_____

C2. How often is the student required to check-in with a provider?

- ☐ Once a week
- ☐ Once a month
- ☐ Every 3-4 months
- ☐ Every 6 months
- ☐ Once a year
- ☐ As needed
- ☐ Other: _____

C3. Is the student currently taking medication(s) for their symptoms?

- ☐ YES
- ☐ NO

If yes, what medication(s) is the student currently taking? For each medication, describe the side effects and any impact on academic performance. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic Impact	Symptoms Persist with Medication?

C4. Please note to what extent each of the following major life activities are affected due to the diagnosis.

1 – Unable to Determine 2 – No Impact 3 – Mild Impact 4 – Moderate Impact 5 – Substantial Impact

Major Life Activities	1	2	3	4	5
Caring for oneself					
Talking					
Hearing					
Breathing					
Seeing					
Walking					
Standing					
Lifting/Carrying					
Sitting					
Performing manual tasks					
Eating					
Working					
Interacting with others					
Sleeping					

Learning/Time Management	1	2	3	4	5
Reading					
Writing: composition					
Writing: spelling					
Math (quantitative reasoning)					
Processing speed					
Stress management					
Listening					
Concentration					
Managing distractions					
Memory					
Planning/Organization					
Time management					
Attending classes regularly					
Timely submission of assignments					

C5. What other specific symptoms manifesting themselves at this time might affect the student's ability to access VCU's programming, facilities, and/or academic opportunities?

_____

_____

C6. What is the student's prognosis? How long do you anticipate that the student's ability to access VCU's programming, facilities, and/or academic opportunities will be impacted by their disability/condition?

_____

_____

C7. Have there been any changes in the student's condition in the past 12 months?

☐ YES (please explain below) ☐ NO

C8. Do you anticipate any changes in the student's condition in the next 12 months?

☐ YES (please explain below) ☐ NO

C9. Is there anything else you think we should know about the student's medical condition and their ability to function academically and/or socially in a college environment?

D. Credentials and Signature

PLEASE TYPE OR PRINT CLEARLY

Name and Title **Professional Qualifications**

Address **City** **State** **Zip Code**

Phone **Fax**

Signature **Date**