DISABILITY VERIFICATION FOR MEDICAL CONDITIONS

This form must be completed in order for students to receive services through the Disability Support Service (DSS) at the University of Maryland, College Park.

★ Documentation must be relevant and appropriate to the diagnosis. It is in the student/clients’ best interest to present documentation, that is, preferably within the last six (6) months.
  - When appropriate, some clients may be asked to provide periodic updates

★ This form is not acceptable documentation for Attention Deficit Disorders (ADD/ADHD), Learning Disabilities (LD) or Psychological disabilities.

Attending physician please complete the following:

Client’s name: ________________________________  ☐ Mr.  ☐ Ms.

Client’s date of birth: _____ / _____ / ______

Client’s phone number: __________________________

Client’s email address: __________________________

Medical Information:

Specific Diagnosis: ______________________________________________________

Initial Date of Treatment: _____ / _____ / ______

Date of Last Visit: _____ / _____ / ______

Date of Next Visit: _____ / _____ / ______

The Expected Duration of the Condition/Disability:

* A disability is defined as a medical diagnosis or physical impairment that substantially limits one or more major life activities, a record of such an impairment or being regarded as having such impairment. The duration of an impairment is one factor that is relevant in determining whether the impairment substantially limits a major life activity.

☐ Permanent  ☐ Temporary: Expected date of recovery _____ / _____ / ______

* Note: Should the student’s condition change (for better or worse), the student must provide updated documentation so his/her accommodations can be adjusted accordingly.
Please check which of the major life activities listed below are affected because of the medical diagnosis. Please indicate the level of limitation.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>NO Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>Concentrating</td>
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<tr>
<td>Memory</td>
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<td>Sleeping</td>
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<td>Eating</td>
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<td>Social Interactions</td>
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<td>Self-care</td>
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<td>Managing internal distractions</td>
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<td>Timely submission of assignments</td>
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<td>Attending class regularly and on time</td>
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<td>Making and keeping appointments</td>
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<td>Stress management</td>
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<td>Organization</td>
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Treatment Plan:___________________________________________________________
________________________________________________________________________
________________________________________________________________________
(If the plan includes study skills workshops, career or personal counseling, the student is expected to arrange for this and follow through on his/her own)
As a result of the aforementioned medical diagnosis, the impact on the student in terms of doing college level work is such that he/she will be:

☐ Totally Incapacitated and should:
  _____ Withdraw from college at this time.
  _____ Not register for college this semester and take a leave of absence.
  _____ Other______________________________________________________________

☐ Partially Incapacitated and has been advised to:
  _____ Reduce his/her academic course load
  _____ Other (please specify) _____________________________________________
________________________________________________________________________
________________________________________________________________________

☐ Minimally Impacted.

* Please indicate what academic accommodations need to be made based on medical necessity (e.g. note takers, extended time for tests, large print etc.)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does the student take any medications? If so, please list quantity and frequency?
1. __________________________ 2. __________________________
3. __________________________ 4. __________________________
Client name: ______________________

What potential side effects are associated with the medication(s) listed above?

________________________________________________________________________
________________________________________________________________________

Given the current medical diagnosis of the student, are there any non-academic accommodations he/she will need? Please list. (e.g. Accessible parking, Para-transit).

________________________________________________________________________
________________________________________________________________________

_______________________________________________

Please return this form within two weeks of receiving it to:

Disability Support Service
University of Maryland
0106 Shoemaker
College Park, Maryland 20742

301.314.7682   Fax: 301.405.0813   Dissup@umd.edu