CHSU COLLEGE OF OSTEOPATHIC MEDICINE

Physical and Systematic Disability Verification Form

Office of Student Affairs, 2500 Alluvial Ave, Clovis, CA 93611

****This form must include ALL of the REQUESTED INFORMATION and be TYPED or PRINTED in order to apply for accommodations through CHSU- COM.****

Student's Name:

_____

Date of Birth:

_____

Address:

_____

Phone Number:

_____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from California Health Sciences University, College of Osteopathic Medicine. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, University Policy requires that a Qualified Professional provide current and comprehensive documentation. A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, nurse practitioner, occupational therapist, physical therapist or other qualified mental health professional *who is not a family member of the student*.

In order to be considered current, an evaluation performed before the student started post-secondary education must have been performed no more than 5 years prior to the student's request for accommodation(s). An evaluation performed during post-secondary education must be no more than 5 years old.

The documentation provided must include information that diagnoses a physical or systemic (medical) disability, describes the functional limitations in an educational setting, indicates the severity and longevity of the physical or systemic (medical) disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication along with any current side-effects which may impact academic performance.

For visual disability, the documentation must include the student's visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged text is recommended as an accommodation.

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To facilitate the gathering of critical information, please respond to the following and return the completed form to CHSU- COM, Student Affairs.

1.Diagnosis:_____

2.Date of Diagnosis: _____

3.Date of Last Professional Contact with Student: _____

4.Provide a summary of the student's educational, medical, and family history that may relate to the disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction):

_____

_____

_____

5.List current medication along with any current side effects that may impact academic performance?

_____

_____

_____

6.Describe the student's functional limitations in an educational setting:

_____

_____

_____

7.Please indicate the RECOMMENDATIONS you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student's educational opportunities at CHSU- COM?

Please check all that apply: ☐ extended time (1.25x) ☐ distraction-reduced environment

☐ Separate Exam Room ☐ Other: _____

Please note: If other accommodations are being requested, additional documentation MAY BE REQUIRED to support the need for additional accommodations.

This student has indicated that you are their provider. The student has requested that you provide this form in support of their request for testing accommodations and has agreed to waive any claim for liability arising out of the information that you provide.

Qualified Professionals Signature: _____

Preferred Name and Tile: _____

Address: _____

Phone Number: _____

Date: _____

NOTE: Our policy regarding documentation prohibits the dissemination of the documentation supporting an accommodation to you or anyone requesting it once it is received by the University. Therefore, once this form is submitted, we will be unable to disseminate copies to anyone.