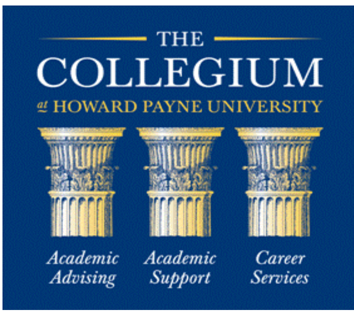


Office of Learning Assistance
1000 Fisk Avenue
Brownwood, TX 76801
Email: cjustice@hputx.edu
Phone: 325 649-8620

Verification of a Physical or Medical Disability

To the Student: ***THIS FORM MUST BE COMPLETED BY YOUR CLINICIAN ONLY.*** The Office of Learning Assistance reserves the right to request additional documentation or contact your clinician for additional information. If this form is completed by anyone other than a qualified licensed professional, the information will not be used to support your accommodation request. Inaccurate and incomplete documentation may result in a delay in your request for services. ***Please note that this form may not be used as documentation for a learning disability or ADD/ADHD. Please sign in the box below giving your health-care provider authorization to release information to the Office of Learning Assistance.***

I, ____, authorize my health-care provider to release to
(Print Student's Name)

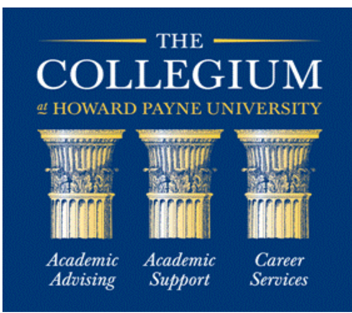
the Office of Learning Assistance the medical information requested on this form for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Howard Payne University.

Signature of patient: ______________________________________Date: ____________________
(Student's Signature)

To the Evaluator: The student whose name appears above has applied for academic accommodations with the Office of Learning Assistance at Howard Payne University. In order for the Office of Learning Assistance to determine his/her eligibility for services, we need your clinical assessment/diagnosis of this student. Please take the time to carefully complete this form and answer all questions. You may fax us a copy, but our records must include an original with your signature and business card. We cannot accept substitutions for this form, but you may provide supplemental information on official letterhead. Feel free to contact us with any questions or concerns you may have. All information provided to us is confidential. We also may contact you directly for supplemental information to make a determination. Thank you for your assistance.

Is the patient currently under your care? No Yes

If yes, for how long? _________________



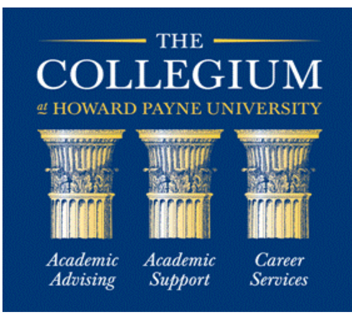
What is the diagnosis/impairment/condition? (Please describe and use ICD 10 diagnostic codes)

Date of Onset: ____/____/______
When did you last see the patient/student? ___/ ___/ _____

Major Life Activities Assessment

Please check and indicate the level of limitation in the **major life activities** listed below which are affected in a learning environment because of an impairment/condition. Note: If retesting was completed to diagnose the condition, please attach any supporting information, e.g., neurological or psycho-educational test reports, etc.

Life Activity	**1 – Negligible**	**2 – Moderate**	**3 – Substantial**
Speaking			
Walking			
Breathing			
Standing			
Reaching			
Lifting			
Sitting			
Caring for oneself			
Performing manual tasks			
Sleeping as it relates to the medical condition you are treating (e.g. due to seizure activity)			
Concentrating as it relates to medical condition you are treating			
Other ________________________			



What are the specific functional limitations resulting from the impairment's impact on the major life activities in a learning environment (e.g. unable to sit for long periods of time; may miss class due to side effects from the condition or medication; unable to handle stairs and inclines)?

Are the functional limitations permanent? No Yes If not, what is the anticipated date of resolution? Prognosis?

List any medications and described effects and possible side-effects on the medical condition you are treating:

If student is currently undergoing treatment (e.g. chemotherapy) please describe the treatment and how it may affect the student in a post-secondary setting.

Note: Test of cognition, information processing, and academic achievement, which may not be part of the diagnostic process itself, may be needed by the Office of Learning Assistance to determine appropriate academic accommodations and services for a student with mobility impairment or other impairment(s) due to a medical condition.

Physician or Licensed Clinical Provider Information:

First: ______________________________ Last: ____

Title: ________________________________ State License Number: _________________________

Address: _________________________________ Phone: _________________________________

City: ____________________ State: ______

Zip: ____________ Fax:______________________

Physician/Provider Signature (stamped signatures are not solely accepted):

____
(Provider Signature)