GRAND VIEW
UNIVERSITY
1200 Grandview Avenue •Des Moines, IA 50316
515-263-2971 • FAX 515-263-6192

Verification Form for Accommodations

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROFESSIONAL

Student Information:

Name____Telephone____________________

Address____

Street Address City State Zip Code

I authorize Grand View University- Academic and Support Center to receive information from my provider (name) ____. I also authorize my provider to discuss my condition (s) with the appropriate and qualified Grand View University personnel on a need-to-know basis.

Student Signature: _________________________________ Date: ______/______/_______

To determine reasonable accommodations, Grand View University requires current and comprehensive documentation of the student's condition. **This form must be completed by a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s).** ***The provider completing this form cannot be a relative of the student***. If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

In compliance with Section 504 of the Rehabilitation Act, the Americans with Disabilities Act and the Iowa Civil Rights Act, Grand View prohibits unlawful discrimination against any qualified student with disability and encourages full participation within the College community. Students with Learning, Psychological, Physical, or Health Disabilities are required to provide comprehensive documentation of their disability to receive appropriate and reasonable services.

Verification of documentation will be kept in a confidential file in the Student Life and Success Center. Grand View University reserves the right to obtain clarification of the diagnosis of the disability, the limitations, and/or the requested accommodation(s) if necessary.

1) Date of Initial Contact with the student: _____/_____/______

2) Date of Last Office Visit with the student: _____/_____/______

3) Describe your history with the student and how long you've worked with them (minimum of 4 sessions, unless an emergent situation):

4) **Diagnosis:** Please list all relevant diagnosis. If applicable, please list all DSM-V or ICD Diagnosis (text and code):

5) If the diagnosis is the result of an emergency or other rapid-onset symptoms, please explain:

6) Please include a summary of your professional assessment of the condition and any diagnostic tools used to make the diagnosis.

7) Does the diagnosis rise to the level of disability? Yes _____ No _____

8) Approximate date of onset: _____/_____/______

9) Approximate duration of condition: ___________________

10) Describe the symptoms related to the student's condition that cause significant impairment in a major life activity:

10) **Severity of symptoms:**

- ○ Mild
- ○ Moderate
- ○ Severe

Prognosis of condition(s):

- ○ Good
- ○ Fair
- ○ Poor

Functional Limitations:

Functional limitations should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

Does this condition significantly **limit one or more of the following major life activities**?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

Recommendations for Academic Success:

11) What have been the historical challenges/barriers in the academic setting?

12) What do you foresee as being challenges/barriers in the university setting?

13) What accommodations **must** occur in the university setting to address the challenges/barriers you specified?

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mail to the Director of Accessibility Services at the address shown at the end of this document.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: ____ Date: ______/______/_______

Print name and Title: ____

State of License: ______________ License Number: ______________________

Address:
____

Phone: ____________________________ Fax:_______________________________

Please complete form, sign, and return to:
Crystal Fierro, MS, MA
Director of Accessibility Services

Grand View University
1200 Grandview Avenue
Des Moines, IA 50316
Email: cfierro@grandview.edu
Phone: 515-263-2971
Fax: 515-263-6192

Attach Provider Business Card Here

*Final determination of appropriate accommodations will be determined by the Director of Accessibility Services at Grand View in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.