Verification Form for Chronic Health Disabilities

Calvin College

Services to students with disabilities, as part of the Academic Services office strives to ensure that qualified students with chronic health disabilities are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Calvin College is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the college programs and services. Federal law defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Some major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking breathing, learning, working, or taking care of oneself. It is important to note that a chronic health condition in and of itself does not necessarily constitute a disability. The degree of impairment should be significant enough to substantially limit one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic accommodations due to chronic health disabilities need to have this form filled out by a certified physician. The physician completing this form must have firsthand knowledge of the student’s condition, must have experience diagnosing and treating this condition and be an impartial professional who is not related to the student.

__________________________________________
Date

Student Signature

Release of Information
I, ___________________________ , hereby authorize the exchange and release of the following confidential information to Academic Services and Calvin College for the purpose of determining my eligibility for educational accommodations.

__________________________________________

Date

Student Signature

Student Information (this section to be completed by student)

Last Name____________________________________ First Name___________________________ MI_

Student ID#________________________________________ Date of Birth ________________________

Address __________________________________________ Phone __________________________

City__________________________________________ State ___________ Zipcode ____________________
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Certifying Professional
Name ____________________________________________________________

Credentials _______________________________________________________

Address __________________________________________ City_________________

State __________ Zipcode __________ Ph. ___________________ Fax __________

License/Certification and state of license __________________________________

Signature of Professional: __________________________

Diagnosis: _______________________________________________________

Basis on which diagnosis was made

____________________________________________________________________

Current medications including dosage and side effects ______________________

____________________________________________________________________

Long term treatment plan _____________________________________________

____________________________________________________________________

Current compliance with treatment plan: YES ☐ NO ☐ Other: ________________

Prognosis for treatment plan. (Include likelihood of improvement or further deterioration and within what approximate time frame.)

____________________________________________________________________

History of hospitalization _____________________________________________

____________________________________________________________________

Implications for Educational Success
Learning abilities specific to the post-secondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc).

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
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Implication for taking exams and other classroom activities caused by the disability or medications.
Please describe and explain why:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Suggested Accommodations
Each recommended accommodation should include a detailed explanation of its relevance to the
disability that is diagnosed. Evaluator also should indicate the level of impaired functioning at which the
individual is currently functioning even with the benefits of treatment.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Final determination of appropriate accommodations will be determined by our office 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.

This form should be returned to:

Calvin College
Academic Services
Attn: Disability Services
1845 Knollcrest Circle SE
Grand Rapids, MI 49546

Phone: 616.526.6113
Fax: 616.526.7066