OFFICE OF DISABILITY SERVICES

1000 Morris Ave Union NJ 07083 TEL: (908) 737-4910 FAX: (908) 737-4865 EMAIL: disabilityservices@kean.edu

VERIFICATION OF MEDICAL CONDITIONS

The student named below has applied for services from the Office of Disability Services at Kean University. In order to determine eligibility and to provide services, we require documentation of the student's disability.

In accordance with Section 504 of the 1973 Rehabilitation Act and the 1990 Americans with Disabilities Act (ADA), the following individualized accommodations have been developed and approved by the Office of Disability Services. Accommodations are intended to provide equal educational access, but not to fundamentally alter the academic standards of Kean University.

Attending Physician please complete the following:

Patient's Name: _____

Patient's Date of Birth: _____

Initial Date of Treatment: _____

Last date of Clinical Assessment: _____

Specific Diagnosis: _____

Duration of Disability/Condition: □ Permanent □Temporary

If temporary, include expected recovery time: □ 1 month □ 6 month □ 1 year

□ other: please specify _____

What impact does the illness have on the patient's ability to perform college level academic work? (Be specific. For example, does this condition affect stamina?)
Use space provided; please write on professional letterhead if additional sheets are needed.

In your professional judgment, to what extent will the illness impact his/her academic functioning?

□ Totally Incapacitated:
Patient should ____ not register_____ withdraw from college until:

Day _____Month _____ Year_____

□ Partially Incapacitated:
Patient should _____reduce his/her course load or _____ (other: please specify)
_____

_____

□ Minimally Incapacitated:
Patient is expected to function adequately with the following academic accommodations:

Please list any medications patient is currently taking. (Please include dosage and frequency).

1.

2.

3.

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

Date of next assessment: Day _____ Month_____ Year_____
Should the patient receive certain nonacademic special considerations?
(For example, handicap accessible parking or mobility van)

Proposed Treatment Plan:

(If treatment plan includes study skills workshops, career or personal counseling sessions, etc., student is expected to follow through with these activities.)

Note: Should the student's condition change (for better or worse), the student must provide updated documentation so his/her accommodations will be adjusted accordingly.

Name and contact information for Attending Physician (please use office stamp)
Physician's Signature: _____ Date: _____

Unless student provides us with proper documentation, the Kean University Office of Disability Services cannot implement any services for him/her.

We ask that you return this form within two weeks of receiving it to:

Donna Dingle
Managing Assistant Director
Office of Disability Services
Kean University
1000 Morris Avenue, Downs Hall Room 127
Union, NJ 07083