

**VERIFICATION OF PHYSICAL/SENSORY DISABILITY
OR MEDICAL CONDITION**

TO BE COMPLETED BY THE APPROPRIATE TREATING CLINICIAN

Date _____

I, the undersigned, certify that:

Name of Student: _____

Date of Birth: _____

Address: _____

Phone: (_____) _____

Has the following diagnosis/condition:

1. Diagnosis/Description of Medical Condition. **INCLUDE ICD-9 or DSM-IV CODE:**

2. Symptoms/Functional Limitations: (e.g., limited ambulation; poor visual acuity; degree of hearing loss):

3. This individual's condition:

Substantially limits him or her in a major life activity Yes No

If yes, what activities are significantly limited? _____

4. Current Treatment(s)/Therapy and Prescribed Medications and Dosage:

5. The medical condition or disability above is:

- Permanent/Chronic
- Long term: 6-12 months
- Short-term/Temporary: 6 months or less
Expected duration: _____

6. The condition or disability is :

- Observable
- Not Observable

7. Please use the space below (and additional sheets as needed) to provide any information that will be helpful to LNEC staff in considering the accommodations that you are recommending. You may choose to address these questions:

- a. Is impact of the condition life threatening if the request is not met?
- b. Is there a negative health impact if the request is not met?
- c. What is the likely impact on academic performance if the request is not met?
- d. What is the likely impact on social development if the request is not met?
- e. What is the likely impact on level of comfort if the request is not met?
- f. Is the request an integral component of a treatment plan for the condition in question?

8. Please list any academic, housing, or other accommodations you recommend:

All recommendations are considered. Decisions are made based on the nature of the disability, reasonableness of the request, and available housing.

**We do not take housing requests for assignments to specific locations. Rather, the LNEC and the Housing office work together to identify housing assignments that best meet each individual's accommodation needs.*

Signature

Date

Name (**Please Print**)

Title

Name of Agency

Phone Number

Fax Number

Street Address

City/State/Zip

All documentation submitted for consideration to LNEC is confidential. When submitting documentation, **please include a copy of any available releases** allowing communication between the LNEC and the diagnostician. Documentation should be sent to:

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