SF SANTA FE COLLEGE

DISABILITIES RESOURCE CENTER (DRC)

## Physical and/or Other Health Disorder(s) Verification Form

Documentation of a disability is necessary for a student to establish their eligibility for academic adjustments, auxiliary aids and services while at Santa Fe College. The following documentation requirement complies with Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Amendments Act. The Disabilities Resource Center requires a student, who self-identifies as having a disability, to provide current (i.e. within the last three years) and comprehensive documentation that verifies a chronic disabling disorder and identifies functional impairments arising from that disorder. Such documentation must be prepared by a healthcare provider who is not a family member of the student and who is qualified by professional training and practice to diagnose and treat the disorder. The confidentiality of all documents submitted to the Disabilities Resource Center are protected under the Family Educational Rights and Privacy Act (FERPA). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.

## Information To Be Completed by Student

Last Name ____________________ First Name ____________________ MI ______ Date of Birth __________

Street Address ____________________ City ____________________ State ______ Zip Code __________

Home Phone # ____________________ Cell Phone # ____________________

## Release of Information Authorization from Student/Patient

I, hereby authorize (Enter Name of Healthcare Provider) ____________________ to release the following information to the Disabilities Resource Center at Santa Fe College for the purpose of determining my eligibility for academic adjustments, auxiliary aids and services while I am a student at the college.

Student's Signature ____________________ Student ID# __________ Date __________

If student is under 18 and/or release is signed by person other than student/patient, state relationship and authority to do so.

Signature of Person on Behalf of Student ____________________ Relationship to Student ____________________

Legal Authority ____________________

## The Following Verification Information To Be Completed by Healthcare Provider

### Diagnostic and Treatment Information

Date of student's initial medical appointment for the Disorder(s) for which you are providing care: ____________________

Date of student's last medical appointment for the Disorder(s) for which you are providing care: ____________________

List Disorder(s) Affecting Student Currently and During the Last Three (3) Years:

| Disorder | Diagnostic Code | Date of Onset |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Identify Procedures Used for Differential Diagnosis of the Disorder(s):

- Physical Examination ☐
- Observations ☐
- Radiological Studies ☐
- Neurophysiological Studies ☐
- Pathology Lab Studies ☐
- Other Minimally Invasive Procedures ☐
- Other Invasive Procedures ☐
- Mini Mental Status Exam ☐
- Neuropsychological Evaluation (Attach Report) ☐
- Psychoeducational Evaluation (Attach Report) ☐
- Medical Hx via Interviews with Student ☐
- Medical Hx via Interviews with Third Party ☐
- Referral for Specialty Consultation ☐

Other Procedures (Specify) ____________________

Provide Brief Summary of Significant Findings From Diagnostic Procedures:

Identify Current Symptoms Associated with the Disorder(s); Level of Severity (i.e., Mild, Moderate, Severe); Frequency of Occurrence (e.g., In Remission, Unpredictable, Episodic, Daily, Weekly,Infrequent, etc.):

Identify Any Situations or Environmental Conditions that Exacerbate the Symptom(s):

History of Hospitalizations in Connection with the Disorder(s)? No ☐ Yes ☐ How Many?

Indicate the Expected Duration of the Disorder:

Temporary (Less than 6 Months) ☐ Date Disorder No Longer Present

Chronic (More than 6 Months) ☐

Permanent ☐

Identify Current Treatment Plan:

Medication ☐

Does Medication significantly limit student's functioning? No ☐ Yes ☐

If Yes Identify Medication and Describe Limit to Functioning:

Therapy ☐

Physical ☐ Frequency (e.g., daily, weekly etc.)

Occupational ☐ Frequency (e.g., daily, weekly etc.)

Respiratory ☐ Frequency (e.g., daily, weekly etc.)

Chemo/Radiation ☐ Frequency (e.g., daily, weekly etc.)

Cognitive Retraining ☐ Frequency (e.g., daily, weekly etc.)

Other ☐ Frequency (e.g., daily, weekly etc.)

Will Treatment Interfere with Student Attending Classes Regularly? No ☐ Yes ☐

If Yes Identify Impact on Regular Class Attendance:

Is Student Complying with Current Treatment Plan? No ☐ Yes ☐

Is the Student Ambulatory? No ☐ Yes ☐

Identify Any Ambulatory Restrictions as to Distance, Time, Use of Stairs or Use of Elevator:

Does the Student Currently Use Mobility Aids and/or Devices? No ☐ Yes ☐

If Yes Identify Mobility Aids and/or Devices the Student Must Use in the Classroom and/or Campus Environment:

Does the Student Currently Use Adaptive/Assistive Technology? No ☐ Yes ☐

If Yes Identify Technology the Student Must Use in the Classroom and/or College Environment:

Does the Student Currently Use a Personal Aide? No ☐ Yes ☐

## Assessment of Major Life Activity Impairments

Impairments that substantially limit one or more major life activity should be determined without considering mitigating measures (i.e. medication, adaptive technology etc.). If disorders are episodic in nature, the level of functional impairment should be assessed based on the active phase of symptoms. Major life activities include, but are not limited to, the life activities and operation of major bodily functions listed below. Please indicate which major life activities and/or functions are affected due to impairments, the severity of impairment and the limit of sustained activity (e.g., minutes, distance, weight).

| Substantially Affected Life Activity | Level of Impairment | Limit of Activity |
|---|---|---|
| ☐ Caring for Oneself | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Performing Manual Tasks | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Seeing | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Hearing | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Eating | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Sleeping | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Sitting | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Walking | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Standing | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Climbing Stairs | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Lifting | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Bending | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Speaking | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Breathing | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Learning | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Reading | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Concentrating | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Thinking | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Communicating | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Working | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |
| ☐ Other -- Specify | None ☐ Mild ☐ Moderate ☐ Severe ☐ | |

| Substantially Affected Major Bodily Function | Level of Impairment | | | |
|---|---|---|---|---|
| ☐ Immune System | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Normal Cell Growth | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Digestive System | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Bowel | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Bladder | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Neurological | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Brain | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Respiratory | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Cirulatory | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Endocrine | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Reproductive | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |
| ☐ Other -- Specify ______ | None ☐ | Mild ☐ | Moderate ☐ | Severe ☐ |

Provide Recommendations for Academic Adjustments, Auxiliary Aids and Services (Must Clearly Be Linked to Impaired Life Activities and Bodily Functions):

## Information To Be Completed by Certifying Healthcare Provider

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

Below Please Sign and Date and Fill in All Other Fields Completely Using PRINT or TYPE

Provider Signature: ______________________ Date: ____________

Provider Name (Print or Type): ______________________ Specialty: ____________

License or Certification No.: ____________ State Issuing Licensure or Certification: ____________

Office Address: ______________________ City ____________ State ______ Zip ______

Office Phone Number: ____________ Office Fax Number: ____________

## All documentation is confidential and should be submitted to:

Disabilities Resource Center
Santa Fe College
3000 NW 83rd Street, Bldg. S, room 229
Gainesville, FL 32606
Phone: 352-395-4400
Fax: 352-395-4100
E-mail: disability.info@sfcollege.edu

Visit our web site: http://www.sfcollege.edu/student/drc/