Medical/Disability Documentation Form
Office of Disability Services

CERTIFICATION OF DISABILITY

To the Student: **This form must be filled out in its entirety by your medical provider or clinician.** If this form is completed by anyone other than a qualified licensed professional, the information provided may not be used to support your accommodation request and the Office of Disability Services reserves the right to request additional documentation. Since a request for additional information can result in a delay in your request for accommodations, you are strongly urged to have the form completed by a qualified medical provider or clinician who will include all requested information.

To the Evaluator: The student named below has represented that s/he has a disability which will require a housing accommodation at Vanguard University. The information you provide will be used to determine the appropriateness of the requested accommodations. **Please take the time to complete this form and thoroughly.** You may fax us a copy, but our records must include an original with your signature. We cannot accept substitutions for this form but you may provide supplemental information on official letterhead. Please contact us with any questions. All information provided to us is confidential and will only be used towards housing accommodations. With the student's permission, we may contact you directly for additional information to assist us in making a determination.

Student Name: ____ **VU ID#**________________________

Health Care Provider: Please respond to the following questions regarding the above named student.

1. Please provide the diagnosis (DSM IV and/or the ICD-9 codes) for the condition(s) for which the accommodation is requested:

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2. Please list date of onset and severity:

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3. How long have you been treating the individual?

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4. When was the last visit you had with the individual?

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5. Please list any *current functional issues and impact on activities* conducted in the classroom and/or academic setting:

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6. What is the current treatment plan (including medications)?

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7. Please provide the results and dates of any testing and/or evaluations used to determine diagnosis and past treatment and response.

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Healthcare Professional Name: ____

Professional Licensure: State___________________ **Number**____________________________

Healthcare Professional Signature: _______________________________ **Date:** _____________

Office Address: ____

Office Phone: ____________________________