



Academic Affairs • Office of Student Accessibility Services
118 Beacon Street • Boston, MA 02116
Phone (617) 670-4429 • Fax 617-670-4439
OSAS@fisher.edu

Disability Verification Form – Physical and Medical Disability

Student Name: _____ Date: _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____ Student ID#: _____

Diagnosis: _____ Date of First Diagnosis: _____

Date of last Clinical Contact: _____

Prognosis/Changes: _____

What is the functional limitation in the academic setting: _____ Mild _____ Moderate _____ Severe

Describe the symptoms (include duration/frequency) of the disorder, how it impacts the student functioning in an academic setting and what might exacerbate these symptoms.

What medications have been prescribed and are there any side effects that may impact the student's academics (Students who are taking medications must inform the College's Nurse)

Recommendations for accommodations given the specific disability (Accessibility Services will consider this to determine services):

Professional's Name/Title (PRINT): _____

License /Certification/Degree _____

Area of Specialization _____ Phone: _____

Employer _____

Address: _____ City: _____ State: _____

Signature: _____ Date: _____

This form must be submitted along with current diagnostic evaluations completed within the past 6 months.