

Verification Form: Mobility Impairments

Rev. 01.22.2025

Albright College's Student Accessibility and Advocacy Office (SAA) has established verification forms to assist in obtaining current information from a qualified professional (e.g., medical physician, neurologist/neuropsychologist, clinical psychologist, licensed counselor, or other relevant provider) regarding a student's condition and symptoms. This form should be filled out by a licensed professional treating this individual for at least three months. To assist the student, we need to understand the student's symptoms, relevant medications and their impact on the student, and the student's need for accommodations. This verification form may supplement information provided in other reports, including medical reports or secondary school documentation. It is not a replacement for a full evaluation or test scores.

- Documentation must show evidence of a disability as defined by the Americans with Disabilities Act as Amended (ADAAA).
- Documentation must be no more than three years old except in rare circumstances.
- Documentation must describe functional impairment affecting an important life skill and how this affects the student in the college environment.
- Documentation must provide history relevant to the student's disability, including treatments, assistive devices, or other pertinent information.
- Documentation must establish a clear link between the recommended accommodation and the student's functional limitations.
- Documentation must present a summary and recommendations.

(Please **print legibly** or **type**; illegible documents will not be processed)

Student Information

Student's Name: _____ DOB: _____

Home Address: _____

Local Address (if different): _____

Cell Phone: _____ Other Phone: _____

Provider Section

Date of Initial Contact with Student: _____

Date of Most Recent Contact with Student: _____

Diagnosis

What is the student's primary diagnosis? _____ ICD-11: _____

When was the student diagnosed with THIS condition? _____

How long have you been treating the student for THIS condition? _____

How often is the student seen for THIS condition (e.g. weekly, monthly) _____

What is the severity of the impairment? Mild Moderate Severe

Explain how you determined the severity above:

How was the student diagnosed/what diagnostic tools or tests were used? (Please submit results with this form)

Do you consider the student to have a disability? Yes No

What is the expected duration of the impairment?

- Short-term (less than six months)
- Episodic
- Long-term (six months to one year)
- Chronic (more than one year, with frequent recurrences)

Please explain why this duration is expected:

(Please **print legibly** or **type**; illegible documents will not be processed)

Current Symptoms

Is the student able to ambulate? No Yes

If yes, how far can the student ambulate without stopping or resting? (e.g., one block, one mile)

If no, how does the student negotiate their mobility restrictions?

Does the student use a manual wheelchair, motorized wheelchair, scooter, crutches, etc? No Yes

If yes, please describe: _____

Can the student negotiate stairs or is an elevator required? _____

Is there clear evidence that the symptoms associated with the student's diagnosis interfere with or reduce the quality of at least one of the following within the academic environment? Please explain in the space provided.

Academic Functioning:

Social Functioning:

Workplace Functioning:

Is there any other historical information related to the student's impairment that you feel is necessary to consider (e.g., medical, psychological, developmental)?

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Pharmacology and Side Effects

Is the student taking any prescribed medications for the diagnosis that you are treating or any other medication that may impact the student's ability to function in the college environment? No Yes

If yes, please provide the information below for each medication the student is prescribed.

Medication/Dosage/Frequency: _____

Date First Prescribed: _____

Side effects that impact the student's functioning (e.g. concentration, sleep, eating):

Medication/Dosage/Frequency: _____

Date First Prescribed: _____

Side effects that impact the student's functioning (e.g. concentration, sleep, eating):

Medication/Dosage/Frequency: _____

Date First Prescribed: _____

Side effects that impact the student's functioning (e.g. concentration, sleep, eating):

Medication/Dosage/Frequency: _____

Date First Prescribed: _____

Side effects that impact the student's functioning (e.g. concentration, sleep, eating):

(Please print legibly or type; illegible documents will not be processed)

Assistive or Adaptive Technology

Is the student utilizing any form of assistive or adaptive technology to facilitate mobility? No Yes

If yes, please describe the specific technology currently used by the student:

Functional Limitations and Recommended Accommodations

It is important for us to understand how the student's current symptoms cause functional impairments in a college environment. Accommodations are not based on the student's diagnosis or medication, but rather on the limitations of their functioning in the educational environment. Based on your knowledge of the student, please provide information regarding reasonable academic accommodations and the rationale for each accommodation based on the student's symptoms. Please attach an additional page if needed.

Symptom: _____

How does this affect the student?

Recommended reasonable accommodation:

Symptom: _____

How does this affect the student?

Recommended reasonable accommodation:

(Please print legibly or type; illegible documents will not be processed)

Provider's Certifying Information

Professionals rendering assessments and diagnoses and providing recommendations for reasonable accommodations must be relevant and qualified to do so (e.g., medical doctor, neurologist/neuropsychologist, psychologist, licensed counselor). The provider signing this form must be the same person who answered the questions above and may NOT be related to the student.

Provider's Signature: _____ Date: _____

Provider's Name: _____

Credentials: _____

License Number: _____ State of Licensor: _____

Office or Business Name: _____

Office or Business Address: _____

Office Phone: _____ Fax: _____

Email Address: _____

Directions for Submitting This Form and Supporting Documentation:

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation, test results/scores, and other supporting documents directly to the SAA Office. Documentation should be faxed to us at 610-929-6793 or mailed to us at:

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