Verification form for Chronic Health Conditions

The University of Vermont (UVM) supports students seeking accommodation for disabilities, including disabilities resulting from Chronic Health Conditions.

Student Accessibility Services at UVM strives to insure that qualified students with disabling chronic health conditions are accommodated in a manner that supports therapeutic treatment. Student Accessibility Services does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life functions. Students whose conditions create a substantial or severe limitation to learning or to other major life activities may request modifications or accommodations to courses and activities at UVM.

Students who wish to receive academic adjustments due to a chronic health condition must have this form completed by a qualified health care provider, which may be a certified physician, other diagnosing medical professional, or specialist (such as, but not limited to: an MD, audiologist, neurologist, endocrinologist). The individual completing this form must have first-hand knowledge of the student’s condition and will be an impartial professional who is not related to the student.

Once this completed form is received, the student will have a meeting with a Student Accessibility Services staff member who will assist in making determination of reasonable and appropriate academic accommodations.

If you have any questions regarding the nature of the information needed for students with Chronic Health Conditions, please contact Student Accessibility Services. This form should be returned to Student Accessibility Services via mail, email or fax.

**STUDENT ACCESSIBILITY SERVICES**
Center for Academic Success
A170 Living/Learning Building
633 Main Street
The University of Vermont
Burlington, VT 05405-0365
Phone: (802) 656-7753
Fax: (802) 656-0739
Email: access@uvm.edu
Office Hours: Monday through Friday from 8:00 A.M. to 4:30 P.M
Student Information (This section to be completed by the student)

Permission to release information to the University of Vermont

Name: (please print) ___________________________ Date: ___________________________

Signed: ___________________________ UVM Student #: 95____________________

*****TO BE COMPLETED BY A CERTIFIED PROFESSIONAL*****

Certifying Professional (please print):

Name: ___________________________ Credentials: ___________________________

Address: City: _______________________ State: _______________________ Zip Code: ________

License/Certification number and state of licensure: ___________________________

Diagnosis: ___________________________

Date of initial contact with student: _________ Date of last contact with student: _________

Basis on which diagnosis was made: ___________________________

Planned current medical/therapeutic interventions:

____________________________________________________________________

Is the student currently using medications: (circle one) Yes No

If yes, what are the medication side effects (if known): ___________________________

____________________________________________________________________
History of hospitalization (please include dates and length of stay):

Please check which major life activities listed below are affected because of the psychological diagnosis. Please indicate the level of limitation.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>No Impact</th>
<th>Minimal Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
<th>Don’t Know</th>
<th>Please describe if moderate or severe impact</th>
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<tbody>
<tr>
<td>Walking (e.g. how far/long can student walk, use mobility devices such as wheelchair, etc.)</td>
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<td>Standing (e.g., duration)</td>
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<td>Sitting (e.g. duration)</td>
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<td>Performing manual tasks (e.g., reaching, manipulating materials &amp; lab equipment, etc.)</td>
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<tr>
<td>Writing/Keyboarding (e.g. unable to keyboard more than 10 min, unable to handwrite, etc.)</td>
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<td>Speech impairment</td>
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<td>Breathing</td>
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<td>Sleeping</td>
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<td>Self-Care</td>
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<td>Hearing (or attach most recent audiogram)</td>
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<td>Vision (or attach most recent eye exam)</td>
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<td>Other (Please describe):</td>
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1. What are limitations that this student will encounter in taking exams and participating in other classroom activities, which are caused by his/her chronic health condition or the medications that he/she is taking?
Please be specific as to exact nature of the limitations and how severe they are:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

2. Recommended accommodations (Final determination of reasonable and appropriate accommodations will be determined by Student Accessibility Services). Each recommended accommodation should include an explanation of its relevance to the disability. Providers are encouraged to include an assessment of the functional limitation, including severity, caused by the disability.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Relevance</th>
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__________________________________________________________________________________

Signature of Certifying Professional

_________________________________________

Date

__________________________________________________________________________________

Street Address

__________________________________________________________________________________

Address (City, State, Zip)

__________________________________________________________________________________

Email Address

This document may not be released without written permission from the student or by order of a court. It will be destroyed seven years after the student is no longer enrolled at the University.

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