FRESNO PACIFIC UNIVERSITY

Office of Disability Access and Education
1717 S. Chestnut Ave.
Fresno, CA 93702-4709
(559)453-7130

Verification of Disability

Student Name:

Student Date of Birth Date:

To establish that an individual has a disability under the law, documentation must indicate that a current mental or physical impairment exists and that the identified impairment substantially limits one or more major life activities. The documentation must also address current functional limitations on the individual and support the request for accommodations. Documentation must be provided by a clinician or treating provider who is licensed and qualified to diagnose the condition and who is not a member of the student's immediate family. Please identify the temporary or permanent physical, medical, mental, or psychological impairment for which the student is seeking a reasonable accommodation.*

*A physical or mental impairment is: (1) an impairment of any system of the body, including but not limited to the neurological system; the musculoskeletal system; the special sense organs and respiratory organs, including, but not limited to, speech organs; the cardiovascular system; the reproductive system; the digestive and genitourinary systems; the hemic and lymphatic systems; the immunological systems; the skin; and the endocrine system; or (2) a mental or psychological impairment. This definition includes learning disabilities, pregnancy, and pregnancy-related conditions. In the case of drug addiction, alcoholism, or other substance abuse, the term "disability" applies only to a person who: (1) is recovering or has recovered; and (2) currently free of such abuse. It does not apply to a person who is currently engaging in the illegal use of drugs or abusing alcohol.

Diagnosis/Description of Condition:
In addition to ICD-10 and/or DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.

___ Structured or unstructured interview with student

___ Developmental history

___ Educational history

___ Medical history

___ Standardized or non-standardized rating scales

Notes: _____

_____

_____

Symptoms/Manifestations of condition:

_____

_____

_____

_____

Treatment/assessment history:
Date the diagnosis was formally established:

Date that the student was last seen:

Is this an ongoing, therapeutic relationship, lasting three sessions or more? Yes No

Expected duration of condition. How long do you anticipate that the student's academic achievement or housing/dietary needs will be impacted by his/her disability?

Current Treatment(s)/Therapy and Prescribed Medications and Dosage:

Does medication and/or side effects have an effect on academic functioning?

Please indicate which of the major life activities listed below are affected because of the condition(s).
Indicate the level of limitation: No Effect, Mild Effect, Moderate Effect, Substantial Effect

Caring for self
Eating
Sleeping
Hearing
Breathing
Listening
Speaking
Seeing
Reading
Standing
Sitting
Walking
Learning
Writing
Concentrating
Memorizing
Performing manual tasks
Interacting with others
Managing internal distractions
Managing external distractions
Managing stress
Organizing
Making and keeping appointments
Regular and timely attendance
Maintaining deadlines

Does this condition substantially limit one or more major life activities? Yes No

If yes, list the specific activity or activities:

Would accommodations help to alleviate barriers to access for this student? Yes No

Optional: You may provide any other information that you believe will be helpful to University staff in considering the accommodations requested by the student.

Emotional Support Animal:
If the student is requesting an emotional support animal, what specific symptoms are alleviated, and how by the presence of this specific animal? Be as detailed as possible.

Can you verify that this specific emotional support animal effectively mitigates this student's symptoms or lessens the barriers in on-campus housing caused by a disability? Or is this merely an expressed wish of the student's? Please explain.

Can you affirm that your relationship with this student is an ongoing, therapeutic relationship, lasting more than 30 days? If so, please include dates of treatment or assessment.

Dietary:
Please note: mild sensitivity, preference, vegetarian/vegan or other lifestyle choices, or financial circumstances do not guarantee a meal plan reduction or a specific housing assignment accommodation. Fresno Pacific University and our contracted catering service reserve the right to make other appropriate accommodations to safeguard the student's health.

List foods that need to be restricted from the diet for medical reasons. Include a brief description of the reason for the restriction (i.e. severe/moderate/mild allergy, acid reflux, sensitivity/ intolerance, etc.):

Please attach results of specific testing or include diagnosis in order for this request to be considered.

Provider information:
I, the undersigned, certify that the information provided for the aforementioned student is true and correct to the best of my knowledge and belief:

Provider Signature

Treating Provider Signature (if in training, please include supervisor signature)

Date

Treating Provider Full Name

Treating Provider's Professional Degree

License Number

Licensed State / Territory