



Verification Form

ADD/ADHD ♦ Communication and Language ♦ Hearing ♦ Medical ♦ Psychiatric

The student listed below requested to register with the Student Access Center (SAC) at Spelman College. The Student Access Center (SAC) requires documentation of the student's diagnosis in order to establish eligibility and provide appropriate services. In order to establish eligibility, the student must provide current, comprehensive documentation that establishes the diagnosis and describes the impact on major life activities, particularly learning and/or residential life.

Under the Americans with Disabilities Act (ADA) 1990 and Section 504 of the Rehabilitation Act of 1973, students are protected from discrimination and may be entitled to reasonable accommodations. In compliance with the requirements set forth, this form is to verify that a disability exists and accompanying the disability are functional limitations. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and/ or services.

Students with physical and/ or chronic medical disabilities may require a specific type of housing to fully participate in the college experience. Requests are considered by the Committee for Disability Housing Accommodations, which is comprised of staff from the Counseling Center, Housing, Student Health Services, Student Access Center and the Associate Vice President of Student Affairs. The Committee evaluates, the student's disability status, the necessity of the requested accommodations, alternative accommodations, and what, if any, housing accommodations would be appropriate for the student.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic and other accommodations. The treating or diagnosing healthcare professional(s) completing this form cannot be related to the student listed below.

Psychological disabilities other than ADD should be within one year of application date and completed and signed by a *Licensed Psychologist* or *Psychiatrist*. Attach a comprehensive *Psychological Evaluation Report* with subtest scores dated within 3 years of application date and signed by a licensed psychologist when providing an assessment for *Neurocognitive* disabilities. For *Hearing* disabilities, please attach the most recent audiogram. *Audiogram* must be dated within one year of application date and signed by a *Licensed Audiologist*. For *Visual* disabilities, please attach recent Acuity and field of Vision. *Vision* assessment must be signed dated within 3 years of application date and signed by an *Ophthalmologist*. *Allergies or Asthma*, please attach allergy or pulmonary function testing results. Test results must be dated within 3 years of application date and signed by an *Allergist*.

The information you provide will not become a part of the student's academic records but will be kept confidential, and placed into the student's file at SAC, where it will be held strictly confidential.

Upon completion of this form, please email, mail or fax the completed document using the information provided above. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. If you have any questions regarding the nature of the information requested on this form, please contact SAC at 404.270.5295 or sac@spelman.edu. Thank you for your assistance.

STUDENT INFORMATION

(Please Print Legibly)

Full Name: _____

Last

First

Middle

Date of Birth: _____ Student ID#: 900 _____

Status: New Student Returning Student Transfer/Exchange Student

Classification: First Year Sophomore Junior Senior PED

Local or Home phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Address (street, city, state and zip code): _____

Spelman E-Mail address: _____@SCMAIL.SPELMAN.EDU

Emergency Contact Name: _____ Relationship: _____

Phone: (_____) _____ - _____

DIAGNOSTIC INFORMATION

IMPORTANT: After review of documentation, the Student Access Center will notify the student acknowledging receipt of documentation and eligibility.

Section I. Section to be completed by a physician or clinician, and may be completed by more than one healthcare professional. Please note if not applicable to this student. The information will provide a plan of support for reasonable accommodation request.

1. Medical Diagnosis DSM-5 or ICD: _____
2. Diagnosis & Date of Diagnosis: _____
3. Date of first contact with student: _____
4. Date of last contact with student: _____
5. In addition to DSM- 5 criteria, how did you arrive at your diagnosis?
 - Structured or unstructured interviews with the student
 - Interviews with other persons
 - Behavioral observations
 - Developmental history
 - Educational history
 - Medical history
 - Neuro Psychological Testing; Dates of Testing: _____
 - Standardized or Non-Standardized Rating Scales: _____
 - Other: _____
6. Is the student/patient currently under your care? Yes No
7. Is this student currently receiving therapy or counseling? Yes No Not Sure
8. What is the severity of the disorder? Mild Moderate Severe
Please describe the severity indicated above: _____

9. What specific symptoms does the student have that might affect her academic performance? _____

10. What is the expected duration of this disability? _____

11. Major Life Activities Assessment:

Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

Life Activity	Negligible	Substantial	Don't Know
Concentrating			
Memory			
Eating			
Social Interaction			
Self-Care			
Regular Class Attendance			
Speaking			
Learning			
Reading			
Thinking			
Communicating			
Keeping Appointments			
Stress Management			
Managing Internal Distractions			
Managing External Distractions			
Sleeping			
Organization			

Section II. Student's History

Please note if not applicable to this student.

- Psychosocial History** - Provide relevant information obtained from the student/parent(s)/guardian(s) regarding the student's psychosocial history (e.g. often engaged in verbal or physical confrontation, history of not sustaining relationships, history of employment difficulties, history of educational difficulties, history of risk-taking or dangerous activities, history of impulsive behaviors, social inappropriateness, history of psychological treatment, etc.) that will assist with providing a plan of academic and other support to the student.

- Pharmacological History** - Provide relevant pharmacological history including an explanation of how medication supports student's academic preparedness. Also include any current medication(s) prescribed including dosage, frequency of use, the adverse side effects, and the effectiveness of the medication in supporting the academic success of the student.

- Educational Accommodation(s) History** - Provide a history of the use of any educational accommodations and services related to any disability listed in this document.

Section III. Accommodations

1. Describe any situations/environmental concerns that may challenge the student's success at Spelman College.

2. State the specific recommendations regarding academic and other accommodations for this student, and a *rationale* as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

3. Students with disabilities may require a specific type of housing to fully participate in the college experience. Requests are considered by the Committee on Disability Housing Accommodations, which is comprised of staff from the Counseling Center, Housing, Student Health Services, Student Access Center, and Associate Vice President of Student Affairs. The Committee evaluates, the student's disability status, the necessity of the requested accommodations, alternative accommodations, and what, if any, housing accommodations would be appropriate for the student.

Housing Accommodations Request:

- Accessible building (*no stairs, elevator building, and accessible common areas*)
- Flash Alarm
- Limited accessible building (*some steps at building entrance, elevator building or ground floor*)
- Private Room
- Refrigerator (*private refrigerators are not permitted in residence halls*)
- Service or Assistance Animal
- Private/Semi-private Bathroom
- Wheelchair Accessible Unit
- Other: _____
- Other: _____

4. If current treatments (*e.g. medications, counseling, etc.*) are successful, state the reasons why the above academic adjustments/accommodations/services are necessary. Please be specific.

5. Please add any additional comments that will be helpful in the review and general application of services and accommodations.

HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and completely fill in all other fields using PRINT.)

Provider's Signature: _____
Date: _____

Provider's Name: _____
Address: _____

License/Cert. #: _____ **State:** _____
Specialty: _____
Phone: _____ **Fax:** _____

Affix business card or apply business stamp within this box