AURORA UNIVERSITY

Dear Health Care Provider,

Our student/your patient has requested accommodations through the Disability Resource Office at Aurora University. The Disability Resource Office provides reasonable accommodations for qualified students with documented disabilities in accordance with the Americans with Disabilities Act (ADA) of 1990 as amended and Section 504 of the Rehabilitation Act. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

You have been asked to complete this Disability Verification Form by your patient. In making the disability determination, please consider if the diagnosis substantially limits one or more major life activities.

Disability documentation must adequately verify the extent of the impairment and clearly substantiate the need for each specific accommodation request.

As the provider completing this form, you should have knowledge of the student's current level of functioning and potential barriers to access in a post-secondary educational environment. Please provide as much detail as you can in regards to if/how the student's impairment is impacting a major life function. Incomplete documentation will delay the eligibility review process.

Accommodations are determined on a case-by-case basis according to documented need, prevailing standards for reasonable accommodations, and an interview with each student. Documentation received will be used in an interactive process with the student to identify strategies for support, including potential modifications or accommodations.

All documents submitted are kept confidential.

Thank you for your assistance in supporting the efforts of our students. If you have any questions regarding this form, please contact me at 630-844-5782.

Sincerely,

Elizabeth Okrzesik

Elizabeth Okrzesik
Disability Accommodations Director
Disability Resource Office

Documentation Guide

Acceptable

- Reports and evaluations completed within the last 3 years from a professional whose expertise within scope of practice for stated impairment
- Includes educational, developmental and medical history relevant to the disability.
- Provide information on how the disability currently interferes with college life

Not Acceptable

- A Diagnosis as only justification for accommodation.
- After Care Instructions
- Incomplete documentation
- Documentation completed by a relative
- Forms completed by professionals whose expertise is outside of scope of the identified disability
- Outdated assessments/evaluations
- Notes written on a prescription pad

Aurora University Disability Verification Form

To be completed by an appropriate professional health care provider

Patients Name: _____ DOB: _____

Diagnosed Disability (include DSM code as applicable): _____

_____

Secondary Impairment(s): _____

_____

Does the impairment limit one or more major life activities?		Yes	No
Would you define this condition or impairment as a disability as per ADA?		Yes	No
Is this student in treatment with you for their disability?		Yes	No
Describe the student's disability:	Stable	Variable	Progressive
Severity of current symptoms:	Mild	Moderate	Severe

Date of Onset/Diagnosis of disability: _____

Date of first clinical contact with student: _____

Date of last clinical contact with student regarding this disability: _____

Date of most recent evaluation or treatment related to the disability: _____

Is follow up treatment required or recommended? If yes when? _____

Is the student compliant with their treatment plan to minimize the impact of their condition? Yes No

How was the diagnosis determined? Check all that apply**. Please submit all diagnostic reports and/or evaluations.**

	Structured interview with the student		Unstructured interview with the student
	Medical History		Educational History
	Behavioral observations		Interview with other persons

	Neuropsychological testing (including the report will assist in determining supporting accommodations)
	Psychoeducational testing (including the report will assist in determining supporting accommodations)
	Other:

Describe the symptoms that meet the criteria for this diagnosis:

_____

_____

_____

_____

_____

_____

_____

Current side effects from medication that are impacting the student:

_____

_____

_____

How frequently does this student experience the above effects to medication? Rarely Occasionally Frequently

Please complete this impact sheet as it relates to the stated disability for your client.
DETAILS ARE REQUIRED FOR MODERATE AND SEVERE DESIGNATIONS.

Life Activity	Mild	Moderate	Severe	Details
Attending Class				
Breathing				
Calculating				
Communicating				
Concentrating				
Driving				
Eating or Diet				
Elimination of Bodily Waste				
Hearing				
Lifting/Carrying				
Memorizing				
Mobility				
Pain Management				
Reading				
Seeing				
Sitting				
Sleeping				
Spelling				
Thinking				
Walking/Standing				
Writing				

Please provide recommendations for accommodations to support the student's access needs and include the rationale for those recommendations.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Final determination of appropriate accommodations will be determined by Aurora University in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.

The information provided is used in the determination of reasonable accommodations at Aurora University. This information is kept in a confidential file within the Disability Resource Office and will not become part of the student's educational record. This document may not be released without written permission from the student or in accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA).

By my signature below, I certify that the information provided above is true and accurate. I confirm I have expertise, history and knowledge of this student's impairment, which meets the standards of a disability as defined by ADA, as amended.

All information below is required

Provider Name (Print): _____

Area of Specialization: _____

Address: _____

_____

Phone: (_____) _____ Fax: (_____) _____

Provider's Signature: _____ Date: _____

Return this document to:

Aurora University Disability Resource Office
347 S. Gladstone Ave**,** Aurora, IL 60506
Confidential Fax: (630) 844-3688
disabilityresources@aurora.edu
Questions? (630) 844-5782