VERIFICATION OF DISABILITY FORM FOR MEDICAL PROVIDERS

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Yeshiva University. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services. **Please take the time to complete this form in its entirety.** Contact the Office of Disability Services with any questions. All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance.

Please note: For hearing disabilities, please attach the most recent audiogram.
For visual disabilities, please attach acuity information.

Student Name:

Medical Diagnosis(es) (DSM-IV if relevant):

Onset of Condition(s):

Current Status of Condition(s) (e.g. Active, Progressing, Controlled, In Remission):

How long is this condition(s) likely to persist (*be as specific as possible: e.g., lifetime, one academic year; one semester; one month*):

What are the student's current functional limitations?

Please describe the current impact that the disability will have on the student's ability to attend and/or participate in class:

Identify any accommodations you believe may be necessary in order for the student to participate in the University's programs, activities and services:

Anticipated duration of need for accommodation:

Additional information:

Name of Medical Professional:

License #:

Please indicate State:

Address:

Telephone:

Signature (verifying that you are not related to the student by blood or marriage):

Date: