

Neurological Disability VERIFICATION FORM

Each student requesting accommodations through the office of Disability Support Services is required to submit documentation to verify eligibility under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Amendments Act (2008). As defined by Section 504 and the ADA, an individual with a disability is a person who has a physical or mental impairment which substantially limits a major life activity. Academic adjustments and other accommodations are implemented to provide equal access to college programs and services.

In order to determine eligibility, a qualified professional must certify that the student has been diagnosed with a disability and provide evidence that it represents a substantial impact to a major life activity (e.g., caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, etc.). It is important to understand that a diagnosis in and of itself does not substantiate a disability. In other words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. DSS requests documentation of a disability for the purpose of establishing disability status, understanding how the disability may impact a student, and providing adequate information on the functional impact of the disability so that effective reasonable accommodations can be determined. Reasonable accommodations are individually determined based upon the information provided by the student in the intake interview and the functional impact of the condition as evidenced by supporting documentation. Prior history of having received an accommodation does not, in and of itself, warrant or guarantee its continued provision. An Individualized Education Plan (IEP) or 504 plan is almost never sufficient documentation of a disability at the post-secondary level.

This documentation form was developed as an alternative to a traditional diagnostic report. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the DSS website (<http://www.shu.edu/offices/disability-support-services/forms.cfm>) in order to view documentation guidelines. DSS expects the following in regard to this documentation form:

- The form will be completed with as much detail as possible as a partially completed form or limited responses may hinder the eligibility process.
- The diagnosis of a medical condition was derived through a formal assessment.
- The assessment information must be current.
- The form is being completed by an appropriate medical professional, who is not a relative of this student, including a licensed neurologist, neurosurgeon, neuropsychologist, or other appropriately trained medical doctor with expertise related to the particular medical condition identified.

Disability Verification Form for Students with Neurological Disability

Student's Name: _____

Date of first contact with student: _____ Date of last contact with student: _____

Date(s) current psycho-educational, psychological, and/or neurological assessment was completed: _____

Frequency of appointments with student (e.g., once a week, twice a month): _____

What is the student's diagnosis? _____

How long has the student had this diagnosis/condition? _____

What is the severity of the condition? Mild Moderate Severe
Explain the severity indicated above: _____

What is the expected duration? Chronic Episodic Short-term
Explain the duration indicated above: _____

Is the condition stable or is it expected to decline? (If it is expected to decline, please explain the expected progression of the condition.) _____

Provide information regarding the student's current symptoms that you feel are relevant to our determination of appropriate academic accommodations or services: _____

Describe any particular procedures used to establish diagnosis that you feel may be useful to us in determining appropriate academic accommodations or services: _____

List the student's current medication(s), including dosage, frequency, and adverse side effects (if applicable): _____

Are there significant limitations to the student's functioning directly related to the prescribed medications?
 Yes No If yes, explain: _____

Provide information regarding the impact, if any, of the condition on a specific major life activity (e.g., learning, eating, walking, interacting with others, etc.): _____

State the student's functional limitations from the disorder specifically in a classroom or educational setting:

Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for reasonable accommodations that you believe will help equalize the student's ability to access the SHU's educational program along with rationale for each): _____

Additional information you believe would be helpful in determining the nature and severity of this student's disability, and any additional recommendations that may assist DSS in determining appropriate accommodations: _____

Certifying Professional

Name and Title

Area of Specialty

License Number

State of Licensure

Address

Phone #

City, State, Zip

Fax #

Signature of Certifying Professional

Date

Please Return To:
Disability Support Services
Seton Hall University
400 South Orange Avenue
Duffy Hall, Room 67
South Orange, NJ 07079
(973) 313-6003 (phone)
(973) 761-9185 (fax)
dss@shu.edu