Johns Hopkins University
Student Disability Services
Disability Verification Form

Please note: A clinician with expertise in the area of the condition following best practices in the field and not related to the student should complete this form.

In order for us to provide disability-related services and accommodation, we need to establish that this individual has a physical or mental impairment that limits one or more of the major life activities, understand the impact of that disability in higher education settings, and determine reasonable accommodations and services that may assist in ameliorating these impacts. Complete documentation guidelines are available at: http://accessibility.jhu.edu/accommodations/

Today's Date: _____

Individual's Name: _____

Student Status (Circle): Undergraduate Graduate Medical Other: _____

Diagnosis/Description of the Functional Impact

1. Please state the condition/diagnosis:

_____

_____

2. How did you arrive at your diagnosis? Please check all relevant items below:

Structured or Unstructured interview	□	Medical tests	□
Interviews with others	□	Medical History	□
Behavioral Observations	□	Developmental History	□

3. Describe the relevant, current impact of the condition on the student in a higher education setting (academic, housing, dining, transportation, social, etc).

_____

_____

_____

_____

_____

History and Prognosis

	Month	Date	Year		Other
Date condition was first diagnosed					
Date individual first seen for the condition					
Date most recently seen for this condition					
Expected duration of condition				Permanent	
How long do you anticipate the impact	3 months	6 months	1 year	More than one year	
Anticipated return to work date				TBD at a later date	
The condition is	stable	improving	worsening	cyclically variable	
The prognosis is	poor	fair	good	excellent	
How often is this individual seen	weekly	monthly	3-6 months	yearly	

4. If the individual is currently taking medication that has side effects and any impact on functioning, please describe below. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic/Work Impact	Persistence of Symptoms

5. Please list any specific accommodations or services to address the functional limitations identified.

_____

_____

_____

_____

6. Do you anticipate any changes in the individual's condition/medication? No Yes Please explain.

_____

_____

7. Is the individual working with another physician or specialist to treat the condition(s)? No Yes
Please explain and indicate who else if known.

_____

_____

8. Is there anything else you think we should know about the individual or their condition?

_____

_____

_____

PLEASE TYPE OR PRINT CLEARLY

Name/Title
_____

Signature_____ Date: _____

License/Certification #_____ State _____

Address _____

City, State, Zip Code_____

Phone _____ Fax _____

Additional information can be submitted in a signed, typewritten letter on letterhead.

Documentation must be returned to Disability Services staff at the specific Johns Hopkins school the student is attending: http://accessibility.jhu.edu/accommodations/student-accommodations/