A logo of a medical company

Description automatically generatedA black and blue logo

Description automatically generated

**Disability & Accommodation Verification Form to be Completed by Physician/Clinician**

* **This form can be filled out in Word or by hand, but the signature of the physician/clinician filling out the form must be original.**
* **Credentials of the diagnosing physician/clinician.**

The physician/clinician completing the form must have the relevant and active professional credentials and license(s) to make the diagnoses. The physician/clinician may not be related to the student. The state(s) in which the physician/clinician has an active and unrestricted license to practice must be included on the form, as well as the NPI (national provider identifier).

* **This form must clearly state the diagnoses.**

Each diagnosis must be specific and reference the DSM-5 or ICD-11 (or the most current edition(s) available at the time of the diagnosis).

* **Each diagnosis must be clearly supported with documentation.**

The documentation should describe the comprehensive testing and/or techniques used to arrive at the diagnoses. It must include the evaluator’s full report, including at least a summary of the assessment procedures and any evaluation instruments used to make the diagnosis along with a narrative summary of the evaluation results and an indication of the limitations that are derived from the diagnosis and testing. The types of assessments/tests used to diagnose conditions/illnesses depend on the accommodations being requested. For example, documentation of a diagnosis would include relevant test results in standard score format with interpretation supporting the diagnosis, and request for extended time for testing due to current functioning would include test results that are valid, standardized to the general population, and use appropriate age-based norms.

* **The information must be current.**

Documentation supporting each diagnosis must be submitted with this form. The documentation must be current since disabilities and a student’s need for an accommodation change over time. In most cases, psychological and/or educational assessments/evaluations should have been conducted within the past five (5) years. Some cognitive and/or neuropsychological assessments/evaluations may have been conducted more than five (5) years ago, but these assessments must have been conducted after the student’s 3rd grade year, as assessments/evaluations prior to that time may not provide a valid or accurate indication of the student’s current abilities. Medical testing should generally be current, typically within the past one (1) year. Physical/musculoskeletal testing or functional assessments should be current, typically within three (3) months. In addition to assessments and evaluations used for diagnosis, documentation must include the student’s abilities and limitations at the time of the request for accommodation. Professionals conducting the testing must have active and unrestricted licenses to do so, and the licensure information must be included in the documentation.

* **The functional limitations must be specifically described.**

The documentation submitted must explain how each diagnosis impacts the student’s daily functioning and ability to participate in any academic or curricular activities, including laboratory activities for their program. Functional limitations related to a diagnosis can be supported with documentation in a variety of ways, such as a formal psychoeducational evaluation report with test scores and narrative, listing standard score test results for the student compared to normed expectations, and/or results from a standard method of measurement of functioning (physical range of motion, laboratory test, etc.).In addition, a summary of the student's developmental, educational, and/or medical history should be included if applicable. These limitations must speak directly to the Health and Technical Standards outlined for the student’s LECOM program.

For reference to complete the functional limitations section, please see the Health and Technical Standards for each LECOM program. <https://lecom.edu/admissions/student-policies/health-technical-standards/>

* **Recommendations for accommodations must be included on the form and must be justified by the assessment/evaluation.**

The documentation submitted should describe the specific accommodations being requested and explain why they are needed. The reason for requesting a particular accommodation is not always evident from the diagnosis. The rationale for specific accommodations should focus on the connection between the student’s diagnosis and the requested accommodations, the student’s current needs, and the reasons accommodations are needed for the student to fully access their LECOM academic program.

For example, requests for extended testing time should document difficulty doing timed tasks, including the amount of extended time required and how the student’s diagnosis creates that need.

Please return the completed form and documentation to the student’s campus.

|  |  |  |
| --- | --- | --- |
| LECOM Erie  Student Affairs Office  1858 W. Grandview Boulevard  Erie, Pennsylvania 16509-1025 |  | LECOM at Seton Hill  Student Affairs Office  20 Seton Hill Drive  Greensburg, Pennsylvania 15601-1548 |
| LECOM Bradenton  Student Affairs Office  5000 Lakewood Ranch Boulevard  Bradenton Florida 34211-4909 |  | LECOM Elmira  Student Affairs Office  1 LECOM Place  Elmira, New York 14901-2037 |

**Complete all fields.**

**Student’s Full Name:** Click or tap here to enter text.

**Student’s Date of Birth:** Click or tap here to enter text.

**Student’s LECOM Campus (Check one below):**

Erie, PA  Bradenton, FL  Seton Hill/Greensburg, PA  Elmira, NY

**Student’s LECOM Program:**

**Date of Initial Contact with Student:**

**Date of Most Recent Contact with Student:**

1. **Please provide information on the current diagnosis or diagnoses (include relevant coding such as current version of DSM and/or ICD code).**

**Diagnosis #1:**

Diagnosis:

Date First Diagnosed:

Describe assessment procedures/evaluations used to make the diagnosis and relevant results: (Attach report or assessment results.)

(Examples: Psychiatric Diagnostic Evaluation, medical records, family history, WISC/WAIS, Woodcock Johson, NEPSY, Conners, PHQ-9, GAD-7, ADHD-RS, MRI or other imaging, physical examination, mental status examination, specific laboratory testing, etc.)

Identify current symptoms and impact (what, frequency, potential triggers, prognosis, settings where symptoms may emerge and the impact of each on the student):

Please list any treatments or interventions being done for this diagnosis as well as if these treatments will have any side effects or needs that may impact the student in the academic setting:

(Examples: Requires more frequent hydration than typical due to the medication, vision or mobility difficulty due to treatment, exposure/response prevention treatment plan in the setting may increase anxiety and distractibility, etc.)

Specify the **current functional limitations** **for this specific student that have an impact in the academic setting** due to this diagnosis (physical, cognitive, learning, behavioral, and/or social):

|  |  |
| --- | --- |
| 1. Choose an item. | Optional description: |
| 1. Choose an item. |
| 1. Choose an item. |
| 1. Choose an item. |
| 1. Choose an item. |

Expected duration of the impact on the student in the academic setting **(Check One)**:

Permanent  Remitting/Relapsing

If remitting/relapsing, please explain the expected duration of impact and the estimated frequency of symptoms that would impact the student in the academic setting:

**Diagnosis #2:**  **Not Applicable** (check is there is no diagnosis #2)

Diagnosis:

Date First Diagnosed:

Describe assessment procedures/evaluations used to make the diagnosis and relevant results: (Attach report or assessment results.)

(Examples: Psychiatric Diagnostic Evaluation, medical records, family history, WISC/WAIS, Woodcock Johson, NEPSY, Conners, PHQ-9, GAD-7, ADHD-RS, MRI or other imaging, physical examination, mental status examination, specific laboratory testing, etc.)

Identify current symptoms and impact (what, frequency, potential triggers, prognosis, settings where symptoms may emerge and the impact of each on the student):

Please list any treatments or interventions being done for this diagnosis as well as if these treatments will have any side effects or needs that may impact the student in the academic setting:

(Examples: Requires more frequent hydration than typical due to the medication, vision or mobility difficulty due to treatment, exposure/response prevention treatment plan in the setting may increase anxiety and distractibility, etc.)

Specify the **current functional limitations** **for this specific student that have an impact in the academic setting** due to this diagnosis (physical, cognitive, learning, behavioral, and/or social):

|  |  |
| --- | --- |
| 1. Choose an item. | Optional description: |
| 1. Choose an item. |
| 1. Choose an item. |
| 1. Choose an item. |
| 1. Choose an item. |

Expected duration of the impact on the student in the academic setting **(Check One)**:

Permanent  Remitting/Relapsing

If remitting/relapsing, please explain the expected duration of impact and the estimated frequency of symptoms that would impact the student in the academic setting:

**Diagnosis #3:**  **Not Applicable** (check is there is no diagnosis #3)

Diagnosis:

Date First Diagnosed:

Describe assessment procedures/evaluations used to make the diagnosis and relevant results: (Attach report or assessment results.)

(Examples: Psychiatric Diagnostic Evaluation, medical records, family history, WISC/WAIS, Woodcock Johson, NEPSY, Conners, PHQ-9, GAD-7, ADHD-RS, MRI or other imaging, physical examination, mental status examination, specific laboratory testing, etc.)

Identify current symptoms and impact (what, frequency, potential triggers, prognosis, settings where symptoms may emerge and the impact of each on the student):

Please list any treatments or interventions being done for this diagnosis as well as if these treatments will have any side effects or needs that may impact the student in the academic setting:

(Examples: Requires more frequent hydration than typical due to the medication, vision or mobility difficulty due to treatment, exposure/response prevention treatment plan in the setting may increase anxiety and distractibility, etc.)

Specify the **current functional limitations** **for this specific student that have an impact in the academic setting** due to this diagnosis (physical, cognitive, learning, behavioral, and/or social):

|  |  |
| --- | --- |
| 1. Choose an item. | Optional description: |
| 1. Choose an item. |
| 1. Choose an item. |
| 1. Choose an item. |
| 1. Choose an item. |

Expected duration of the impact on the student in the academic setting **(Check One)**:

Permanent  Remitting/Relapsing

If remitting/relapsing, please explain the expected duration of impact and the estimated frequency of symptoms that would impact the student in the academic setting:

**2. Recommended Accommodations:**

Based on your professional evaluation of the student, please describe the specific accommodations recommended for this studentrelated to the functional limitation(s) listed above:

|  |  |
| --- | --- |
| **Accommodation:**  Please be specific in description | **Limitation Addressed**  (Two limitations available for each if needed) |
| Click or tap here to enter text. | Choose an item.  Choose an item. |
| Click or tap here to enter text. | Choose an item.  Choose an item. |
| Click or tap here to enter text. | Choose an item.  Choose an item. |
| Click or tap here to enter text. | Choose an item.  Choose an item. |
| Click or tap here to enter text. | Choose an item.  Choose an item. |

**Additional Comments:**

**Physician/Clinician completing this form must complete this section also:**

Print full name:

Signature:

Date form completed and signed:

Title/Credentials:

State(s) of active and unrestricted licensure, type of license, and license number for each:

NPI (national provider identifier):

Address:

Phone:

Fax:

**Thank you for your time in providing this information.**

June 2024