DIVISION OF
STUDENT AFFAIRS
COUNSELING CENTER

Accessibility and Disability Service
0106 Shoemaker Building
4281 Chapel Lane
College Park, Maryland 20742
301.314.7682 TEL
301.405.0813 FAX

Verification of Medical Disability for Accomodations

This form must be completed to receive accomodations through the Accessibility and Disability Service (ADS) at the University of Maryland, College Park. The student named below has applied for services from the Accessibility and Disability Service (ADS) at the University of Maryland College Park. In order to determine eligibility and to provide any requested services, we require documentation of the student's medical disability.

Under the Americans with Disabilities Act (Amendments Act) of 1990(2008) and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities and has an expected duration of not less than 6-8 weeks. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

Criteria:

1. **Documentation to be submitted no later than six months of form completion.**
2. **The medical provider completing this evaluation cannot be a relative of the student or a close family friend.**
3. **This form is not acceptable documentation for Attention Deficit Disorders (ADD/ADHD), Learning Disabilities (LD) or Psychological disabilities. Please find the appropriate form on counseling.umd.edu/ADS.**

_____ Student Name (print above)

_____ Student Date of Birth (print above)

_____ Student UID# (print above)

_____ Student Contact Number

_____ Student Email Address

Student's Gender: ☐ Male ☐ Female ☐ Trans/male ☐ Trans/female ☐ Gender queer/non-conforming

☐ Different identity (Please state): _____

Student Name:_____

The following section is to be completed by the student's medical provider:

Medical Information:

Specific Diagnosis: _____

Initial Date of Treatment: _____

Date of Last Visit: _____

Date of Next Visit: _____

The Expected Duration of the Condition/Disability:
(To be eligible for Accessibility and Disability Service, a medical condition or injury must substantially limit at least one major life activity (e.g. seeing, walking, etc.) and have an expected duration of **6 weeks or longer**.)

☐ Permanent

☐ Temporary: Expected date of recovery

Please check which of the major life activities listed below are affected due to the medical diagnosis. Please indicate the degree to which there are limitations.

Life Activity	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating	☐	☐	☐	☐
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Memory	☐	☐	☐	☐
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Sleeping	☐	☐	☐	☐
	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Eating	☐	☐	☐	☐

	NO Impact	Moderate Impact	Substantial Impact	Don't Know
Social Interactions.	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Self-care	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Managing internal distractions.	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Managing external distractions	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Timely submission of assignments.	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Attending class regularly and on time	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Making and keeping appointments.	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Stress management	☐	☐	☐	☐
	NO Impact	**Moderate Impact**	**Substantial Impact**	**Don't Know**
Organization	☐	☐	☐	☐

Student Name:_____

Treatment Plan:

As a result of the aforementioned medical condition, the impact on the student in terms of performing college level work is such that he/she will be:

- ☐ Totally Incapacitated and should:
  - ☐ Withdraw from college at this time.
  - ☐ Take a leave of absence from the University of Maryland for medical reasons
  - ☐ Other
- ☐ Partially Incapacitated and has been advised to:
  - ☐ Reduce his/her academic course load
  - ☐ Other (please specify)
- ☐ Minimally impacted

1. Does the student take any medications? If so, please list quantity and frequency.

2. What potential side effects are associated with the medication(s) listed above?

3. Please indicate the academic accommodations needed based on medical necessity (e.g. note takers, extended time for tests, large print, etc.).

Recommended Accommodation	Justification

Student Name:

4. Given the current medical condition of the student, are there any non-academic accommodations he/she will need? Please list. (e.g. accessible parking, para-transit, etc.)

Please use office stamp.

Print Name of medical provider: _____

Physician Signature: _____ **Date:** _____

Address: _____

Phone number: _____

Email Address: _____

Please return this form within two weeks of receiving it to:

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