DIVISION OF
STUDENT AFFAIRS
COUNSELING CENTER

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

Verification of Medical Conditions for Disability Accommodations

This form must be completed to receive services through the Disability Support Service (DSS) at the University of Maryland, College Park.

Criteria:

1. **Documentation must be current (within last six (6) months).**
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/DSS.**

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

Patient's name: _____

Patient's sex: ☐ **Male** ☐ **Female** ☐ **Trans/male** ☐ **Trans/female**

☐ **Other:** _____

Patient's date of birth: _____

Patient's phone number: _____

Patient's email address: _____

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 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

Patient Name:_____

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	☐	☐	☐	☐

Patient 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. Please indicate the **<u>academic accommodations</u>** needed based on medical necessity (e.g. note takers, extended time for tests, large print, etc.). Please include a brief justification.

Patient name:

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

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: _____

Address: _____

Phone number: _____

Email Address: _____

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

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dissup@umd.edu