SJSU SAN JOSÉ STATE UNIVERSITY

Medical Disability Verification Form

SJSU Administration Bldg., Rm 110, One Washington Square, San Jose, CA 95192-0168 · (408) 924-6000 v.; (408) 924-5990 TTY; (408) 924-5999 f.

To Evaluator: To qualify for support services from the Accessible Education Center at San José State University, an individual must have his/her disability verified by an appropriate licensed professional. Documentation necessary to substantiate the diagnosis must be comprehensive and be based on a comprehensive diagnostic/clinical evaluation.

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please note: Student medical records supplied to this office constitute "education records" under the Family Education and Privacy Act (FERPA) and as such, may be reviewed by the student upon written request.

For general questions pertaining to this form, or to obtain clarification about the information requested, please contact a AEC counselor at (408) 924-6000.

Verification requested for: _____

Student Name: (Last, First M.I.)

To be completed by licensed practitioner:

Name: _____ Phone: _____

How often do you see this student? _____ Date of student's last visit: _____

Length of time this student has been under your care: _____

Diagnostic Information:

Diagnosis #1: _____ Date of Diagnosis: _____

Duration of Diagnosis: ☐ Permanent ☐ Progressive ☐ Chronic ☐ Temporary - through: _____ (date)

Diagnosis #2: _____ Date of Diagnosis: _____

Duration of Diagnosis: ☐ Permanent ☐ Progressive ☐ Chronic ☐ Temporary - through: _____ (date)

Based on your diagnosis, how does the student's functional limitations* affect the student's ability to perform and function in an academic and test-taking environment (i.e. disorders of thinking, psychosis, reading comprehension, attention span, alertness, response speed, motor functions, writing, calculating, etc.)?

**Functional limitations are substantial limitations in an individual's ability to perform in a condition, manner, or duration of a required major life activity.*

Major Life Activity:

Does the impairment affect a major life activity? ☐ Yes ☐ No

If yes, what major life activity(ies) is/are affected? *Please check the level of limitation you believe this student experiences as a result of his/her's disability(ies). Check only those boxes that apply.*

1 = Unable to determine 2 = Mild 3 = Severe

1	2	3	Major Life Activity
			Walking
			Speaking
			Breathing
			Hearing
			Seeing
			Thinking
			Sitting
			Reaching
			Interacting w/ others
			Communicating
			Learning
			Reading

1	2	3	Major Life Activity
			Performing manual tasks *(including household chores, bathing, brushing teeth)*
			Bending
			Concentrating
			Caring for oneself
			Lifting
			Sleeping
			Working
			Reproduction
			Sexual functions
			Eating

1	2	3	Major Life Activity
			Running
			Controlling bowels
			Standing
			Operation of major bodily functions *(including functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.)*
			Other:

Is the student limited in one or more of these major life activities? ☐ Yes ☐ No

Prescribed Medication:

1. Name of Medication w/ Dosage: _____ 1. Purpose of Medication: _____

_____ _____

Medication Side Effects that Impact the Student. *Please check all that apply:*

☐ Confusion/Thought Disorder ☐ Impaired Coordination ☐ Sedation/Fatigue ☐ Agitation

☐ Decreased Concentration ☐ Distractibility ☐ Psychomotor Impairment

☐ Other: _____

2. Name of Medication w/ Dosage: _____ 2. Purpose of Medication: _____

_____ _____

Medication Side Effects that Impact the Student. *Please check all that apply:*

☐ Confusion/Thought Disorder ☐ Impaired Coordination ☐ Sedation/Fatigue ☐ Agitation

☐ Decreased Concentration ☐ Distractibility ☐ Psychomotor Impairment

☐ Other: _____

3. Name of Medication w/ Dosage: _____ 3. Purpose of Medication: _____

_____ _____

Medication Side Effects that Impact the Student. *Please check all that apply:*

☐ Confusion/Thought Disorder ☐ Impaired Coordination ☐ Sedation/Fatigue ☐ Agitation

☐ Decreased Concentration ☐ Distractibility ☐ Psychomotor Impairment

☐ Other: _____

4. Name of Medication w/ Dosage: _____ 4. Purpose of Medication: _____

_____ _____

Medication Side Effects that Impact the Student. *Please check all that apply:*

☐ Confusion/Thought Disorder ☐ Impaired Coordination ☐ Sedation/Fatigue ☐ Agitation

☐ Decreased Concentration ☐ Distractibility ☐ Psychomotor Impairment

☐ Other: _____

Certifying Licensed Physician or Primary Health Care Provider qualified in the appropriate specialty area.

(Must be completed by a licensed practitioner)

Name: _____

(Last, First M.I.)

Medical Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

License Number: _____

Signature: _____ Date: _____

For general questions pertaining to information requested, please contact the Accessible Education Center at 408-924-6000

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