

Medical/Physical Disability Diagnosis Verification

The student named below may be eligible for disability accommodations at Samuel Merritt University. In order to determine appropriate accommodations, Samuel Merritt University must have verification of a disability and of the resulting functional limitations. Information on this form will be used in confidence for the educational benefit of the student. This information will be kept strictly confidential.

First Name	Middle Initial	Last Name	Date of Birth
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Description and date of diagnosis(es): _____

Describe the functional limitations and severity of impact on the student in an educational setting: (Please note that accommodations will be determined based on documented, specific functional limitations.)

Describe any treatment, medications and important side effects from medications: _____

The above documented diagnosis is: permanent/chronic temporary until _____
Month/Date/Year

Certifying Professional;
Diagnoses must be within the professional expertise and scope of practice of the certifying professional.

Name (typed or printed)	Signature
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Title	License No.	Today's Date
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Address	City	State	Zip	Telephone	FAX
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