

**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.

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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

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*Certifying Professional;*

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

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