MITCHELL | HAMLINE
School of Law

Disability Services Medical Verification Form

Student Name: _____ **Date of Birth:** _____

MHSL ID: _____

For Healthcare Provider/Treating Practitioner

This DS Verification Form may be completed by a qualified healthcare provider to better understand the student's disability-related functional limitations and accommodation needs. A qualified healthcare provider is generally trained, certified, or licensed in their field. If you have questions, please contact Disability Services in the Dean of Students Office at disabilityservices@mitchellhamline.edu or by phone at (651) 290-6343.

Health Care Provider Name: _____

Title & Specialty: _____

License/Certification Number and Issuing State: _____

Organization: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Phone: _____ Email: _____

Disability Services uses a multi-source process to determine eligibility for disability-related accommodations. Information considered may include the student's self-report, history of accommodations (when available), diagnostic information, assessment findings, and clinical information. While Disability Services reviews all information submitted by treating providers, they are only one component of the interactive review process. The determination of reasonable accommodations rests solely with the institution and is based on an individualized assessment of the student's functional limitations, the essential requirements of the academic program, the technical standards of the institution, and the reasonableness of the requested accommodation(s) within the academic setting.

The remainder of this form should be completed, signed, and dated by the healthcare provider listed above.

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Diagnostic Information

Please provide information that reflects the students' current functional limitations and accommodation needs. If the diagnosis or evaluation is historical, please indicate whether the student's current presentation remains consistent with the information provided.

1. Please list the diagnosis/es and any co-existing diagnoses. *Please attach relevant diagnostic or assessment information, if available.*

   Primary: _____ Date: _____

   Co-Existing: _____ Date: _____

   Co-Existing: _____ Date: _____

2. Severity of the condition's current impact:
   Mild: _____ Moderate: _____ Severe: _____

3. Nature of the condition(s):
   Acute: ____ Episodic: ____ Chronic: ___ In Remission: ____

4. Prognosis: What is the expected duration or course of the condition (e.g. temporary, ongoing, episodic, or permanent)?

5. Are there circumstances or factors that increase the student's symptoms, functional limitations, or barriers? If so, please describe.

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Functional Limitation Information

A ***functional limitation*** describes how a disability affects a person's ability to perform an activity or access an environment.

Please rate the frequency/duration and severity of the condition's impact in the following areas to the best of your knowledge. If further explanation would help describe the student's functional limitations or barriers, please attach additional information.

**Frequency/Duration Scale: 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic*

Area of Functional Impact	Frequency/Duration 0-4 scale*	Severity			
		Mild	Moderate	Severe	Unknown / N/A
Attending Class					
Following Directions					
Initiating Activities					
Interacting with Others					
Listening					
Managing Distractions					
Meeting Deadlines					
Memory					
Organizational Skills					
Problem Solving					
Processing Speed					
Speaking					
Standing or Sitting					
Sustained Reading					
Sustained Writing					
Thinking/Concentrating					
Other:					

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Accommodation Information

A diagnosis alone does not determine whether an individual is disabled or eligible for accommodations under the Americans with Disabilities Act Amendments Act (ADAAA). Reasonable accommodations are based on the student's functional limitations and the barriers they create in the academic environment.

Reasonable accommodations are modifications or adjustments that provide students with disabilities equal access to academic programs and services. They are not intended to guarantee academic success or alter essential academic requirements and technical standards.

Please indicate your recommendation for accommodations within the post-secondary environment and briefly explain how each recommended accommodation relates to the student's functional limitations or barriers. Although provider recommendations are carefully considered, Mitchell Hamline School of Law remains the sole authority to determine what accommodations are reasonable and appropriate.

Accommodation:
Rationale:

Accommodation:
Rationale:

Accommodation:
Rationale:

Healthcare Provider Signature: _____ Date: _____

Thank you for your cooperation in completing this form.

Completed forms may be returned to the student or submitted directly to:

Mitchell Hamline School of Law
Office of Disability Services
Dean of Students Office
875 Summit Avenue
St. Paul, MN 55015
Email: disabilityservices@mitchellhamline.edu