COLUMBIA HEALTH
Disability Services

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VERIFICATION OF DISABILITY FORM FOR MEDICAL PROVIDERS

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Columbia University. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services. **Please take the time to complete this form in its entirety.** Contact Disability Services at (212) 854-2388 (V/TTY) with any questions. All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance.

Please note: For hearing disabilities, please attach the most recent audiogram.

For visual disabilities, please attach acuity information.

Student Name: _____

Dates of treatment with current provider/facility:

_____

_____

Date student was last seen: _____

Medical Diagnosis(es): _____

_____

Onset of Condition(s): _____

_____

Current Status of Condition(s) (e.g. Active, Progressing, Controlled, In Remission):

_____

_____

_____

How long is this condition(s) likely to persist (*be as specific as possible: e.g., lifetime, one academic year; one semester; one month*):

_____

_____

What are the student's current functional limitations (*again, be as specific and detailed as possible and provide information for all disability areas*): 1) ambulation; 2) upper extremity motor function; 3) hearing; 4) vision; 5) cognitive processes—concentration, rapidity of information processing, fatigability, others:

_____

_____

_____

_____

_____

_____

In comparison to the average person in the general population, please rate the severity of the student's functional limitations noted above, both with and without the use of mitigating measures (interventions), such as medication and treatment:

Without Mitigation (Intervention):	**With Mitigation (Intervention):**
Mild □	Mild □
Moderate □	Moderate □
Substantial □	Substantial □
Severe □	Severe □

What exacerbates the specific disability(ies) this student has? (*again, be as specific and detailed as possible*)

_____

_____

_____

_____

Please list any medications related to the condition(s) that the student is currently taking, including dosage and frequency, if pertinent. Please include both the positive as well as any negative effects of the medication:

_____

_____

_____

_____

Please describe the impact that the student's condition will have on his/her ability to attend or participate in classes and/or live in University Housing:

_____

_____

_____

_____

Please describe the impact this student's condition has on his/her overall ability to learn, or on other cognitive abilities:

_____

_____

_____

Identify any accommodations you believe may be necessary in order for the student to participate in the University's programs, activities and services:

_____

_____

_____

Anticipated duration of need for accommodation: _____

Name of Medical Professional: _____

License #: _____

Please indicate State: _____

Address: _____

Telephone: _____

Signature (verifying that you are not related to the student by blood or marriage):

_____

Date: _____