

**TO:**

**FROM:**

**Webster University**

**RE: Criteria For Documenting Physical/Health Disabilities**

The following student, \_\_\_\_\_ (DOB \_\_\_\_\_), has applied for support services available to qualified individuals with disabilities through Webster University. Current and comprehensive documentation of the student's disability must be on file with Webster University in order to determine appropriate and reasonable accommodations. The student has indicated that you could provide this documentation, along with information pertinent to the kinds of accommodations the student may need to function successfully in a college environment. We ask, therefore that you address the criteria outlined below on professional letterhead or complete the attached verification form. A signed release of information form is enclosed.

**CRITERIA FOR DOCUMENTING PHYSICAL/HEALTH DISABILITIES**

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| <ol style="list-style-type: none"><li>1. A clear statement of the DSM-IV or ICD diagnosis, including pertinent history.</li><li>2. Current documentation (the age of acceptable documentation is dependent upon the disabling condition).</li><li>3. A summary of assessment procedures, including all scores, used to make the diagnosis.</li><li>4. A description of present symptoms, fluctuating conditions/symptoms, and diagnosis.</li><li>5. Other medical information to be considered in a postsecondary educational environment. This includes current medication needs.</li><li>6. Suggestions of reasonable accommodations (Must be supported by the diagnosis).</li><li>7. A description of personal care concerns.</li></ol> |
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**WEBSTER UNIVERSITY DISABILITY VERIFICATION FORM**  
**STUDENTS WITH PHYSICAL/HEALTH DISABILITIES**

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ I.D. #: \_\_\_\_\_

**DIAGNOSTIC INFORMATION**

ICD/DSM-IV diagnosis: \_\_\_\_\_

Date of onset: \_\_\_\_\_

Diagnostic criteria/tests used: \_\_\_\_\_  
\_\_\_\_\_

Describe the functional nature of the disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prognosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the disability currently stabilized? \_\_\_\_\_ If no, describe variables: \_\_\_\_\_  
\_\_\_\_\_

**MEDICATION/TREATMENT INFORMATION**

Describe current medication needs, side effect(s), if any and possible effects of the medication on the student's educational performance: \_\_\_\_\_  
\_\_\_\_\_

How long has the student been taking this medication? \_\_\_\_\_

Is the student still adjusting to or stabilized on the medication? \_\_\_\_\_

Is the student compliant with medication as prescribed? \_\_\_\_\_

Does the student need to take medication during class hours? If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

Does the student continue to need accommodations when utilizing the recommended medications? \_\_\_\_\_  
\_\_\_\_\_

**INFORMATION SUPPORTING ACCOMMODATION REQUESTS**

Describe the student's functional limitations in an educational setting: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there crisis episodes associated with the disability? \_\_\_\_\_ If so, describe: \_\_\_\_\_

Describe any restrictions: \_\_\_\_\_

Please describe any mobility issues/concerns associated with the student's disability: \_\_\_\_\_

Will the disability affect the student's class attendance? If yes, please explain. \_\_\_\_\_

Have you any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level? (Describe services/ accommodations in exam administration, classroom or study activities, or course requirements). \_\_\_\_\_

**OTHER INFORMATION**

Assistive devices: \_\_\_\_\_

**If the student has accompanying seizure activity, please describe the following:**

Type of seizure activity: \_\_\_\_\_

Severity: \_\_\_\_\_

Frequency and length of typical seizure activity: \_\_\_\_\_

Emergency procedures which should be followed: \_\_\_\_\_

**CERTIFYING AUTHORITY**

**SIGNATURE:** \_\_\_\_\_

**PRINT NAME AND TITLE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Please accompany this form with a note on your professional letterhead describing how long and under what conditions you have treated this patient.