

TO:

FROM:

Webster University

RE: Criteria For Documenting Recovering Chemical Dependency

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 RECOVERING CHEMICAL DEPENDENCY
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| <ol style="list-style-type: none">1. A current DSM-IV diagnostic statement.2. A clear statement of successful completion of a supervised drug/alcohol rehabilitation program.3. A dated statement attesting to the compliance with appropriate post-rehabilitation treatment.4. A summary of assessment procedures and evaluation instruments used to make the diagnosis.5. A summary of qualitative and quantitative information which supports the diagnosis.6. Medical information to be considered in a college environment, including medication needs.7. Suggestions of reasonable accommodations (should be supported by the diagnosis). |
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WEBSTER UNIVERSITY DISABILITY VERIFICATION FORM
STUDENTS RECOVERING FROM CHEMICAL DEPENDENCY

STUDENT NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ I.D. #: _____

DIAGNOSTIC INFORMATION

ICD/DSM-IV diagnosis: _____

Has the student completed a supervised drug/alcohol rehabilitation program?

Yes _____ No _____ In process _____

Pertinent History: _____

Assessment procedures and evaluation instruments used: _____

Prognosis: _____

MEDICATION/TREATMENT INFORMATION

Describe current medication needs and side effects and how the medication will affect 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 the medication regime as prescribed?

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

INFORMATION SUPPORTING ACCOMMODATION REQUESTS

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

How will the disability affect the student's class participation (attending lectures, doing research, writing papers, reading large amounts of information, meeting deadlines, working in small and large groups, etc). _____

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 for exam administration, classroom or study activities, or course requirements). _____

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.