Disability Access and Education
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https://www.fresno.edu/students/disability-access-and-education

FRESNO PACIFIC UNIVERSITY

Verification of Disability

I request that this form be completed and returned, along with any supporting documentation regarding my condition to: ◯ Disability Access and Education Office (see above) ◯ Myself

Student Signature _____ Date _____

The Disability Access and Education office at Fresno Pacific University provides services and/or accommodations for students with disabilities intended to facilitate equal access to educational opportunities. To determine eligibility for services and/or accommodations, current and comprehensive documentation regarding a physical or mental condition and its impact on the student's function is required from a licensed medical professional qualified to diagnose and treat the particular condition(s).

To be Completed by Licensed Professional Only**

Name of Student _____ Date of Birth _____

Beginning date of treatment _____ Date of Last Contact _____

Does the student have a disability that impairs a major life function? ◯ Yes ◯ No

Is this an on-going therapeutic relationship? ◯ Yes ◯ No

What is the anticipated duration of the current symptoms?
◯ 6 months ◯ 1 year ◯ more than 1 year ◯ Chronic ◯ other _____

How might the student's disability affect his/her academic performance? _____

_____

_____

How might the disability affect living on or getting around campus? _____

_____

_____

**This form will be disregarded if it is completed by a relative or someone whose primary relationship to the student is that of a friend.

Major Life Activities

Below is a checklist of major life activities that could be affected by the student's condition. Please check all that apply.

Major Life Activity	No Effect	Mild Effect	Moderate Effect	Substantial Effect
Caring for one's self	◯	◯	◯	◯
Eating	◯	◯	◯	◯
Sleeping	◯	◯	◯	◯
Hearing	◯	◯	◯	◯
Breathing	◯	◯	◯	◯
Listening	◯	◯	◯	◯
Speaking	◯	◯	◯	◯
Seeing	◯	◯	◯	◯
Reading	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Sitting	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Learning	◯	◯	◯	◯
Writing	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Memorizing	◯	◯	◯	◯
Performing manual tasks	◯	◯	◯	◯
Interacting with others	◯	◯	◯	◯
Managing internal distractions	◯	◯	◯	◯
Managing external distractions	◯	◯	◯	◯
Managing stress	◯	◯	◯	◯
Organizing	◯	◯	◯	◯
Making and keeping appointments	◯	◯	◯	◯
Regular and timely attendance	◯	◯	◯	◯
Maintaining deadlines	◯	◯	◯	◯

For any item below, attach additional sheets and/or test results if necessary.

List any current medications, dosages, frequency and/or side effects that may affect the student's academic performance.

_____

_____

What are your recommendations for reasonable accommodations? _____

_____

_____

If applicable, list foods that need to be restricted from the diet. Include a brief description of the reason for the restriction (i.e. severe/moderate/mild allergy, acid reflux, sensitivity/intolerance, etc.):

_____

_____

If student is requesting an emotional support animal, what specific symptoms are alleviated and how by the presence of an animal?

_____

_____

Is there evidence that your recommended accommodations or treatment, which may or may not include an emotional support animal, mitigates the student's symptoms or lessens the barriers caused by a disability to college-level coursework and/or living in on-campus housing? Please explain or attach test results, if applicable.

_____

_____

HEALTHCARE PROVIDER INFORMATION

The information provided is accurate to the best of my knowledge and the condition for which I treat the student is within the scope of my professional licensure or certification.

Print Name, Title, Credentials _____

_____

Address_____ Phone# _____

Signature _____ Date _____

□ A business card must be attached for application for services/accommodations to be considered.