



### Student Verification of Disability Form

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I, \_\_\_\_\_, authorize the release of necessary confidential medical information regarding my disability. I am requesting disability accommodations through the Office of Academic Affairs at Arkansas Colleges of Health Education (ACHE). The school requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability-related accommodations. Please respond to the following questions as soon as possible and return to me or send to the disability office by mail or fax. I authorize the Office of Academic Affairs to contact you if clarification is needed.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare provider name (print): \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Organization and address: \_\_\_\_\_

The following area must be completed by the healthcare professional listed on this page. Page 4 may be utilized if additional space is required.

1. Diagnosis(es) and date(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Current status of condition(s) (e.g., active, progressing, controlled, in remission):

\_\_\_\_\_  
\_\_\_\_\_

3. Current level of severity (circle one):            Mild                    Moderate                    Severe

4. How long is this condition(s) likely to persist (be as specific as possible—e.g., lifetime; 1 academic year; duration of academic program enrollment; 1 month, temporary):

\_\_\_\_\_

5. Please list procedures/assessments used to diagnose this student's condition:

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6. What are the functional limitations or symptoms of the condition(s)?

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Additionally, what major life activity(s) (includes major bodily functions) is/are affected?

- |  |  |                                   |                                   |                                 |
|--|--|-----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Bending         | <input type="checkbox"/> Hearing                 | <input type="checkbox"/> Reaching | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Breathing       | <input type="checkbox"/> Interacting with Others | <input type="checkbox"/> Reading  | <input type="checkbox"/> Standing | (describe)                      |
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Learning                | <input type="checkbox"/> Seeing   | <input type="checkbox"/> Thinking |                                 |
| <input type="checkbox"/> Concentrating   | <input type="checkbox"/> Lifting                 | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Walking  |                                 |
| <input type="checkbox"/> Eating          | <input type="checkbox"/> Performing Manual Tasks | <input type="checkbox"/> Sleeping |                                   |                                 |

Major bodily functions:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Digestive     | <input type="checkbox"/> Lymphatic             | <input type="checkbox"/> Reproductive                |
| <input type="checkbox"/> Bowel          | <input type="checkbox"/> Endocrine     | <input type="checkbox"/> Musculoskeletal       | <input type="checkbox"/> Respiratory                 |
| <input type="checkbox"/> Brain          | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological          | <input type="checkbox"/> Special Sense Organs & Skin |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hemic         | <input type="checkbox"/> Normal Cell Growth    | <input type="checkbox"/> Other: (describe)           |
| <input type="checkbox"/> Circulatory    | <input type="checkbox"/> Immune        | <input type="checkbox"/> Operation of an Organ |  |

7. What exacerbates this student's specific disability(ies)? (Please be as specific and detailed as possible)

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8. How does the condition (and/or current treatment) impact the student's ability to learn or meet the demands of the university setting and/or clinical requirements?

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

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This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified healthcare provider.

Providers name (Please print): \_\_\_\_\_

Professional license or specialty: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Physician/Clinic Stamp or Seal**  
Signature required if no stamp available

Thank you for your cooperation. You may email your report to the Office of Academic Affairs at [studentaccommodations@achehealth.edu](mailto:studentaccommodations@achehealth.edu). Please call 479-308-2300 if you require additional information. Please attach any additional reports or relevant information. All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

