Sacred Heart UNIVERSITY

Office of Student Accessibility: Disability Verification Form

Student Name (required): _____

Student Sacred Heart University ID (required): _____

To be eligible for disability services the individual requesting (student) must have a documented disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 and Amendments of 2008 defined as a physical or mental impairment that **substantially** limits one or more major life activities.

Please note:

- Any information provided to the Office of Student Accessibility (OSA) becomes part of the student's "educational record". Under privacy protections and access provisions of FERPA, the student, when requested, has the right to inspect their educational records.
- A learning disability diagnosis must be accompanied by a current and appropriate psychoeducational evaluation, including the diagnostic test scores.
- Additional documentation may be required by the OSA

For the Treating Clinician and/or Diagnostician:

You have been asked by your patient/client to complete this verification form providing documentation of a disability based on Section 504 of the Rehabilitation Act and The Americans with Disabilities Act of 1990 and Amendment of 2008. Please complete this form in its entirety and attach any additional information. Verification forms returned partially complete could result in a delay or denial of accommodations. To accurately complete this form, you must:

- Have knowledge of the student's **current level of functioning** and any potential access barriers this may present at the university level
- Complete the following verification form with current knowledge of the student
- If you have any questions about this process or require assistance, contact Kathy Radziunas (radziunask@sacredheart.edu) or Laurie Scinicariello (scinicariellol@sacredheart.edu).

Full Student Name (first, middle, last) (required): _____

Student date of birth (required) _____

Full Student Address (required) _____

Date of initial office visit (required) _____

Date of most recent office visit (required) _____

Formal diagnosis (required) _____

Date of diagnosis (required) _____

Expected duration of diagnosis (permanent, temporary, chronic, episodic, and reoccurring) (required):

Methodology used to obtain diagnosis and symptoms that determine the diagnosis (required):

Date of most recent testing and/or evaluation: _____

Please attach any test results and/or diagnostic reports.

Severity of condition (required): ☐ mild ☐ moderate ☐ substantial

Current medications, dosage frequencies, and potential adverse side effects of these (required):

Current therapies and other treatments, frequencies of these and anticipated hospital stays (Required)

Relevant background information including developmental, medical, academic, psychosocial, family etc. (required):

Substantial Impact on Major Life Activities:

Definition: **The patient/client's activities are significantly restricted when compared to the average individual in the general population when considering the conditions, manner, or duration under which the activities can be performed.**

Functional Limitation, please check all that apply (this section required):

Area of functional Limitation:	**Mild**	**Moderate**	**Substantial**	**Impact symptoms may have on academics and/or residential life (residential life specific to housing request)**
Caring for Oneself	☐	☐	☐	
Performing Manual Task	☐	☐	☐	
Seeing	☐	☐	☐	
Breathing	☐	☐	☐	
Sleeping	☐	☐	☐	
Eating	☐	☐	☐	
Standing	☐	☐	☐	
Lifting	☐	☐	☐	
Bending	☐	☐	☐	
Walking	☐	☐	☐	
Speaking	☐	☐	☐	
Learning	☐	☐	☐	
Reading	☐	☐	☐	
Concentrating	☐	☐	☐	
Thinking	☐	☐	☐	
Communicating	☐	☐	☐	
Memory	☐	☐	☐	
Working	☐	☐	☐	
Operation of a Major Bodily Function	☐	☐	☐	
Other	☐	☐	☐	
Other	☐	☐	☐	

Additional information:

Suggested Reasonable Accommodations:

Each suggestion and rationale must be supported by a diagnosis previously documented on this form.

Please note- suggested accommodations will be considered but are not automatically included as part of a student's reasonable accommodations at Sacred Heart University.

1. Suggested Accommodation

   Rational

   Functional Limitation this may accommodate

2. Suggested Accommodation

   Rational

   Functional Limitation this may accommodate

3. Suggested Accommodation

   Rational

   Functional Limitation this may accommodate

Practitioner Name & Title (required): _____

Practitioner Signature (required): _____

Specialty/Qualifications for Determining Diagnosis (required): _

State License and/or Certification number (required): _____

Address: _____

Phone: _____

Date form signed (required): _____

This form may be completed and saved as a PDF, then submitted by fax (203- 396- 8049) or through our secure file management system using the following steps:

Please Do Not Email Documentation.

MFT documentation management system:

Please use our Managed File Transfer (MFT), our official web-based, file transfer system, to send documents and images securely to Sacred Heart University. **Files of a sensitive nature should not be emailed**. Multiple files can be uploaded at once, each file must be less than 7MB in size. The following file types are accepted: documents (doc, docx, xls, xlsx, pdf) and graphics (jpeg, jpg, png, tif).

Use the following website URL to access the site: SHUMFT. Recommended browsers are Google Chrome, Firefox, Microsoft Edge, and Safari; Internet Explorer does not display information correctly. Users will be required to register for an account before being able to upload a file.

Be sure to name documents using the students name before you upload them.

During the upload process, you will be required to select the appropriate department folder. Please choose **Office of Student Accessibility**. We will receive an email confirmation once the file is available for access.