RELEASE OF INFORMATION
FOR VERIFICATION OF MEDICAL OR PHYSICAL IMPAIRMENTS

The student completes the following:

I, ______________________________, hereby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for academic accommodations.

Student’s Signature ________________________________  Phone: ______________________________
Student’s Z# ________________________________  Date of Birth: ______________________________

Please return the completed information to the appropriate campus:

☐ Florida Atlantic University
   Student Accessibility Services
   777 Glades Road, SU 133
   Boca Raton, FL 33431
   tel: 561.297.3880  fax: 561.297.2184

☐ Florida Atlantic University
   Student Accessibility Services
   3200 College Avenue, LA 131
   Davie, FL 33314
   tel: 954.236.1222  fax: 954.236.1123

☐ Florida Atlantic University
   Student Accessibility Services
   5353 Parkside Drive, SR 111F
   Jupiter, FL 33458
   tel: 561.799.8585  fax: 561.799.8819

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INFORMATION FOR DIAGNOSTICIAN

To ensure the receipt of reasonable and appropriate accommodations, students needing services must provide current documentation of their disability. FAU Student Accessibility Services is required to maintain confidential records of this student’s conditions for the purpose of accommodation according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendment Act of 2008.

This documentation should provide information regarding the onset, longevity, and severity of symptoms, as well as specifics describing how it interferes with educational achievement. Assessment of current functioning is necessary.

Thank you for your assistance.
VERIFICATION OF MEDICAL OR PHYSICAL IMPAIRMENTS
(To be completed by a medical doctor or other licensed medical provider.)

Patient’s Name: ___________________________ Date of Most Recent Examination: ____________

Your input will assist us in determining what accommodations are appropriate to provide the student equal access to programs, services, and learning.

1. Diagnosis: ____________________________________________________________

2. Prognosis: Permanent _____ Temporary _____ How long? __________________________

3. Does the disability limit mobility?  Yes ____  No ____  If yes, does the student have difficulty with: Walking: ________ Speed: _____ Distance: _____ Stairs: ___________ Extended Standing: ________ Extended Sitting: ____________

4. Please describe any problems the student has in any of the following areas:
   Pain: ____________________________________________________________________
   Fatigue: __________________________________________________________________
   Vision: ___________________________________________________________________
   Hearing: __________________________________________________________________
   Hand/arm mobility: _________________________________________________________
   Attention: __________________________________________________________________
   Living Environment: _______________________________________________________

5. Does this disability affect academic pursuits or living environment? Yes ____  No ____  If yes, please describe __________________________________________________________________

6. Is the student on any medication that may affect attention, concentration, any other facet of learning, or living environment?  Yes ____  No ____
   Medication: _______________________________________________ Indication/Usage: __________
   Medication: _______________________________________________ Indication/Usage: __________
   Medication: _______________________________________________ Indication/Usage: __________
   Side Effects: __________________________________________________________________

7. Is there any other information which should be taken into consideration in determining appropriate academic/living accommodations? ________________________________________________________________

Please attach any additional documentation which you feel may help us determine the most appropriate assistance for this student.

Physician Name (Print) _______________________________________________________

Physician Signature _________________________________________________________

Credentials _______________________________________________________________

Phone ___________________________ Date __________________________

*Please attach your business card.