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 ___

4. If yes, does the student have difficulty with: Extended Standing: _________ Extended Sitting: _________

5. Is the student on any medication that may affect attention, concentration or any other facet of learning?
   Yes ___ No ___
   Medication: ________________________________________________________________ Indication/Usage: __________
   Medication: ________________________________________________________________ Indication/Usage: __________
   Side Effects: ____________________________________________________________________

6. Describe in detail the student’s functional limitations associated with this diagnosis. How might this disability impact the student academically?
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

7. Are there any specific academic accommodations you would recommend for this student? __________
   _______________________________________________________________________
   _______________________________________________________________________

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.*