Medical/Mental Health Verification Form

Hope College Disability and Accessibility Resources
PO Box 9000 Holland Mi, 49422-9000
Phone # 616-395-7925
Fax # 616-395-7617

Due to the specific nature of a request for accommodation(s), alternate forms or letters may not be accepted and will delay the process.

Please note: All requests are reviewed on a case by case basis and accommodations are determined through an interactive process with the student. The purpose of an accommodation is to provide access to the same information, interactions and services as all other students. A medical diagnosis alone and a recommendation for a specific accommodation may not establish an access related need for accommodations. Determinations are made by connecting functional limitations associated with a disability and the mitigating effect of the accommodation and these can vary greatly among individuals with the same diagnosed condition.

Part 1 (to be completed by student)

g professional for
e condition described in

d until all required

Date:_____ Signature:_____

Student Information

Last Name:_____ First Name:_____ M.I.: _____

Student ID #:_____ Phone#:_____

Date of birth:_____

Address:_____

City: _____ State:_____ Zip: _____

Part II (to be completed by physician, or mental health provider) Diagnoses of disabilities documented by family members are not accepted.

Relevant Diagnosis (disability, acute, or chronic medical or psychological condition):

_____

_____

Primary symptoms/behavior addressed in treatment, including date of onset:

_____

_____

_____

Brief history of presenting problem: _____

_____

_____

_____

Past treatment: _____

_____

_____

Current treatment, including specific medication(s), and compliance: _____

_____

_____

_____

Description of any current functional limitations. Functional limitations are restrictions in the ability to perform an action/activity or the way in which a condition limits or impacts a person. Please include specific restrictions for physical activity if applicable.

_____

_____

_____

Implications in the academic environment: _____

_____

_____

Implications for campus accessibility: _____

_____

_____

Implications in a residential setting (housing): _____

_____

_____

Licensed Physician/Mental Health Provider (please print)

Name: _____

Credentials: _____

Address: _____

City_____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

License # and State of License: _____

Signature of Licensed Physician/Mental Health Professional:

_____

Date: _____

Return this completed Medical/Mental Health Verification Form to:

Hope College Disability and Accessibility Resources | Fax# 616-395-7617 | dar@hope.edu