SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

ACCESS Medical Verification & Functional Impact Form

Section 1: Student Information and Authorization

Student's Name: _____

Student 800#: _____ Date: _____

I authorize Accessible Campus Community & Equitable Student Support (ACCESS) at SIUE to release and/or receive information from/to the provider below. I also authorize my provider to discuss my condition(s) with the ACCESS office for the purposes of approving a housing accommodation:

Student Signature: _____

Section 2: For Completion by Medical Provider

Your patient has self-identified to the ACCESS office as having a physical disability or a chronic health condition covered by the Americans with Disabilities Act as Amended (ADAAA). The following questions are based upon the documentation requirements guidelines issued by the Educational Testing Services (www.ets.org) and Association for Higher Education and Disability (www.ahead.org).

Provider Information

Name of Provider: _____

License #: _____ State: _____

Address: _____

Phone #: _____ Fax #: _____

Medical Facts

Please provide a specific diagnosis (or diagnoses) of the student's condition. Note that a diagnosis in and of itself does not automatically warrant approval of requested accommodations.

Disability/Diagnosis: _____

Major Life Activity Limitation(s): Based on the student's condition, please describe any functional limitations they may have in performing a major life activity. A current functional limitation is a substantial impairment in an individual's ability to function with respect to the condition, manner, or duration of a required major life activity. Examples include walking, sitting, standing, seeing, hearing, speaking, breathing, learning, working, caring for oneself and performing manual tasks.

Medication(s): If the student is taking medication for this condition(s), how might the medication impact the student? Please include information about what medications are being taken by the student and what adverse impacts if any they may have on their educational pursuits:

Recommendations and Rationale: We would like to have rationale for each recommended accommodation to be provided based upon a medical reason. If there are specific accommodations you feel would be necessary for this student's academic support, or accommodations that the student is requesting which you can affirm, please list those below. If there is any other information you feel would be helpful in assisting this student, please also provide this information.

_____

Medical Provider's Signature **Date**

Upon completion, please return to ACCESS office at Southern Illinois University Edwardsville by email or fax.