Brenau University
1878

Office of Accessibility Services

Provider Verification Form

Physician/Evaluator Name: _____

Dates of Testing/Evaluation: _____

Address and Phone Number: _____

Patient's Name: _____

Patient's DOB: _____

In order to evaluate requests for accommodations or auxiliary aids under the Americans with Disabilities Act and under Section 504 of the Rehabilitation Act of 1973, students must provide adequate documentation to our office. Any documentation provided to our office is strictly confidential and used solely for the purposes of determining reasonable accommodations. **Please note there is a separate form and process for requesting Emotional Support Animals (ESAs) or other housing-related accommodations.** Please contact the Director if information is needed regarding the housing accommodations application process.

I. Diagnostic statement identifying the condition/disability (attach relevant documentation):

_____

_____

_____

II. Detailed history of condition/disability:

_____

_____

_____

_____

_____

_____

III. Description of current symptoms and how they affect patient physically/academically:

_____

_____

_____

_____

_____

_____

IV. Severity of symptoms: _____

V. Expected progression or stability of condition/symptoms:

_____

_____

_____

_____

VI. Medications prescribed and side effects that may impact class or fieldwork setting:

_____

_____

VII. Accommodations recommended and why:

_____

_____

_____

_____

_____

VIII. Additional information that may assist in determining accommodations:

_____

_____

IX. Functional Limitations that impact academic performance:

a. Learning: _____

_____

b. Writing: _____

_____

c. Reading: _____

_____

d. Math: _____

_____

e. Concentrating: _____

_____

f. Interacting with Others: _____

_____

g. Seeing: _____

_____

h. Hearing: _____

_____

i. Attending Class: _____

_____

j. Sitting/Standing:_____

_____

k. Walking:_____

_____

l. Other: _____

Provider Name (Please Print): _____

Provider Signature: _____ Date: _____

Provider License Number/Credentials: _____

Phone Number: _____

Please attach business card below: