

JOHNSON 
STATE COLLEGE
JOHNSON, VERMONT

**Physical Disability Verification Form
To Be Completed By Disability Provider**

You are being asked to provide documentation of a physical disability for your client, _____ (dob _____) (SS# _____). Please fill out the form below and attach the appropriate supplemental documentation. Thank you in advance for your support and cooperation in this matter.

I _____ give permission for the release of information to Johnson State College.

(Student's Signature) _____

Practitioner Name/Title _____ Date _____

Address _____

License or Certification number _____

Specialty/qualification to make diagnosis _____

Date of last appointment _____

To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such impairment, or (3) is regarded as having such an impairment. "Major life activities" are functions such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, reproduction, and working.

1. Nature of disability (Formal Diagnosis). Please include expected duration: _____

2. Severity of condition. (Mild, Moderate, Severe, etc.) _____

3. Check all relevant functional limitations are substantially limited.

____ Walking ____ Hearing ____ Seeing ____ Working ____ Sleeping ____ Caring for self

____ Interacting with others ____ Learning (including memory/concentration)

____ Performing manual tasks ____ Other _____

4. Please explain how each functional limitation will specifically affect your client in the academic environment. _____

5. Please suggest reasonable accommodations. Each recommendation must be supported by the diagnosis. Please discuss the rationale for each suggested accommodation relating it to a specific functional limitation. _____

6. Please state alternatives to meet the documented need if the first request cannot be met. _____

7. Please discuss the impact on your client's disability if the accommodation cannot be granted. _____

8. Additional comments: _____

Please note that the Learning Specialist will make all final decisions on which reasonable accommodation will be granted.

Signature of Diagnostic Practitioner Date

Please Return This Form and Supporting Materials To:
The Learning Specialist
Academic Support Services
Johnson State College
337 College Hill
Johnson, VT 05656

Telephone: (802) 635-1259
TTY: (802) 635-1456
FAX: (802) 635-1454

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