

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)

I, _____, hereby authorize the exchange and release of the following confidential information to Hope College Disability Services. The purpose of this disclosure is to determine my eligibility for accommodations based on medical/mental health conditions.

I give consent for Hope College Disability Services to contact my treating professional for additional information as needed. Any such discussion will focus on the condition described in this form only.

I understand that my request for accommodations cannot be addressed until all required documentation is received by Disability Services.

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