STUDENT LIFE
UNIVERSITY OF MICHIGAN

Services for Students with Disabilities
G-664 Haven Hall
Ann Arbor, Michigan 48109-1045
Voice (734) 763-3000 Fax (734) 936-3947

Chronic Health Condition Verification Form

The University of Michigan is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective accommodations, auxiliary aids and services for qualified students with documented disabilities. The purpose of these services is to provide equitable access to all aspects of the University's programs. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that any diagnosed condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

The office of Services for Students with Disabilities (SSD) strives to insure that qualified students with chronic health conditions are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the student's condition, must have experience diagnosing and treating college students and will be an impartial professional who is not related to the student.

Student Information (this section to be completed by the student)		
Last name:	First:	Middle Initial:
Student number:	Date of Birth:	
Address:		
City:	State:	Zip code:
Phone number:	Email address:	

Certifying Professional (this section is to be filled out by the verifying professional)		
Name:		
Credentials:		
Address:		
City:	State:	Zip code:
Phone number:	Email address:	
License/Certification number:	State of Licensure:	
Years of experience working with a college aged or adult population:		
Date of **initial contact** with student:		
Date of **last contact** with student:		

I. Diagnosis
Date of Diagnosis:

II. Basis on which diagnosis was made

III. Current medications including dosage and side effects

IV. Other therapeutic interventions

V. Current compliance with medication plan and/or therapeutic intervention

VI. Long term medication and treatment plan

VII. Prognosis for medication plan and/or therapeutic intervention
Include likelihood of improvement or further deterioration and within what approximate time frame.

VIII. History of hospitalization

IX. Implications for educational success

Learning abilities specific to the post-secondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc.)

X. Implications for taking exams and other classroom activities

Either caused by the disorder or medications. Please specify which.

Suggested Accommodations

Final determination of appropriate accommodations will be determined by the SSD Office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws. Each recommended accommodation should include a detailed explanation of its relevance to the disability that is diagnosed. Evaluator also should indicate the level of impaired functioning at which the individual is currently functioning even with the benefits of treatment.

If you have any questions regarding the nature of the information needed for students with chronic health conditions, please call Services for Students with Disabilities at (734) 763-3000, Monday through Friday from 8:00am to 5:00pm Eastern Standard Time. This form should be returned to G-664 Haven Hall, University of Michigan, Ann Arbor, Michigan, 48109-1045 or faxed at (734) 936-3947.

This document may not be released without written permission from the student or by order of a court. It will be destroyed after three years after the student is no longer enrolled. The student will have access to this document but you may specify that this access be given when there is a person qualified to explain the document is available.

Signature of Certifying Professional Date