

MERCER UNIVERSITY MEDICAL VERIFICATION OF DISABILITY FORM – Graduate/Prof

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Mercer University. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services. **Please take the time to complete this form in its entirety.** Contact Disability Services at (478) 301-2778 with any questions. All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student if over age 18 prior to the release of this form. Thank you for your assistance. This form is available on-line at www.mercer.edu/disabilityservices

For psychological disabilities form must be dated within one year and completed and signed by a licensed psychologist or psychiatrist.

For neurocognitive disabilities please attach a comprehensive Psychological Evaluation Report with subtest scores, dated within 3 years and signed by a licensed psychologist.

For hearing disabilities, please attach the most recent audiogram dated within one year. Audiogram must be signed by a licensed audiologist.

For visual disabilities, please attach recent acuity and field of vision dated within 3 years. Vision assessment must be signed by an ophthalmologist.

For allergies or asthma, please attach allergy or pulmonary function testing results dated within 3 years. Test results must be signed by an allergist.

For Any Disability, Additional or More Recent Documentation May Be Required

Student Name: _____

Medical Diagnosis(es)(DSM or ICD): _____

Onset of Condition(s): _____

Date of Last Visit for Condition: _____

Current Status (e.g. Active, Progressing, Controlled, In Remission) _____

GAF score if applicable: _____

Expected Duration of each medical condition (lifetime, one year, one semester, one month): _____

What are the student’s current functional limitations (*again, be as specific and detailed as possible and provide information for all disability areas*): 1) ambulation; 2) upper extremity or fine motor function; 3) hearing; 4) vision; 5) cognitive processes—concentration, rapidity of information processing, memory, fatigability, others:

In comparison to the average person in the general population, please rate the severity of the student’s functional limitations noted above, both with and without the use of mitigating measures (interventions), such as medication and treatment:

Without Mitigation (Intervention):

- Mild
- Moderate
- Substantial
- Severe

With Mitigation (Intervention):

- Mild
- Moderate
- Substantial
- Severe

What exacerbates the specific disability this student has? (*again, be as specific and detailed as possible*) _____

Please list any medications related to the condition that the student is currently taking including dosage and frequency. Please include both the positive as well as any negative effects of the medication (attach a separate sheet if necessary):

Please describe the impact that the student's condition will have on his/her ability to attend or participate in classes:

Please describe the impact this student's condition has on his/her overall ability to learn, or on other cognitive abilities:

Identify any accommodations you believe may be necessary in order for the student to participate in the University's programs, activities and services:

Anticipated duration of need for accommodation: _____

Name of Medical Professional: _____

Specialty: _____

License # and State: _____

Address: _____

Telephone: _____

Signature (verifying that you are not related to the student by blood or marriage):

Date: _____

Mail: Disability Services, Mercer University, 1400 Coleman Ave, Macon, GA 31207
Confidential Fax: (478) 301-2127 Attn: Carole Burrowbridge – Director Disability Services