Office of Title IX and Equity
305 Administration Bldg
800 University Drive
Maryville, MO 64468

Phone: 660.562.1873
Fax: 660.562.1424

VERIFICATION FORM FOR CHRONIC HEALTH DISABILITIES

Northwest Missouri State University (NWMSU) is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equal access to the University's programs and services. 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 difficulties with attention do 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 Title IX and Equity (A & A) strives to ensure that qualified students with Chronic Health Disabilities 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 activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to an Chronic Health Disability should have this form filled out by a doctor, physician's assistant or nurse. The professional 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.

This form is not the only part of this process. Equally and sometimes more important will be your interview with A&A staff. Ideally, this would happen before you begin attending class.

Student Information *(This section to be completed by the student.)*

Last Name _____ First Name _____ Middle Initial _____

ID Number (919) _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Certifying Professional

Name _____ Credentials _____

Address _____

City _____ State _____ Zip Code _____

License/Certification number and state of licensure _____

Years of experience working with college students _____

Date of initial contact with student _____ Date of last contact with student _____

Please provide diagnosis/diagnoses and the corresponding dates below.

Basis on which diagnosis was made _____

Current medications, including dosage and side effects

Long term medication plan _____

Current compliance with medication plan _____

Prognosis for medication plan (Include the likelihood of improvement or further deterioration and within what approximate time frame) _____

Other planned therapeutic interventions _____

Prognosis for therapeutic interventions (Include likelihood for improvement or further deterioration and within what approximate time frame) _____

Current compliance with therapeutic interventions _____

History of hospitalization

Implications for Educational Success

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

Implications for taking exams and participating in other classroom activities caused by the disorder or medications that he/she is taking? Please specify

Suggested accommodations (Final determination of appropriate accommodations will be determined by the A&A 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 be accompanied by an explanation of its relevance to the disability that is diagnosed.

If you have any questions regarding the nature needed for students with psychiatric impairments, please call the Office of Title IX and Equity at **(660) 562-1873, Monday through Friday from 8:00 a.m. to 5:00 p.m.**, Central Standard Time. This form should be returned to **305 Administration Building, 800 University Drive, Maryville, MO 64468-6001** or faxed to us at **(660) 562-1424**.

This document may not be released without written permission from the student or by order of a court. It will be destroyed seven years after the student is no longer enrolled. This 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 available.

Signature of Certifying Professional _____ Date _____

Signature required