Office of Accessible Education
275 Eastland Road
Berea, Ohio 44017
https://www.bw.edu/accessible-education
Email: disability@bw.edu
Fax: (440) 826-3832

Neurological Disorder Verification Form

The Office of Accessible Education (OAE) provides services and accommodations for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activity. For a student to be considered eligible to receive reasonable accommodations, the documentation must show the functional limitations that impact the individual in the post-secondary setting.

OAE requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Baldwin Wallace University generally requires documentation prepared within the last 36 months (3 years). The University reserves the right to request updated or more extensive documentation as appropriate. The information outlined below is necessary to evaluate eligibility for accommodations.

- The professional(s) conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so. These persons generally are trained, certified or licensed physicians, neurologists, clinical psychologists, or neuropsychologists.
- All parts of the form must be completed as thoroughly as possible.
- The provider should attach any reports which provide additional, related information. A copy of a relevant evaluation report may be submitted as documentation, in lieu of this form, as long as it is comprehensive, current, and meets all of the documentation requirements as outlined in the Baldwin Wallace University General Guidelines for Documentation, available at http://www.bw.edu/accessible-education.
- The information provided on this form is NOT part of the student's permanent educational record, but will be maintained with OAE.

STUDENT INFORMATION (Please Print)

Name (Last, First, Middle): _____

Date of Birth: _____ BW ID Number: _____

Status (check one): ☐ current student ☐ transfer student ☐ prospective student

Phone: (_____) _____ - _____ BW Email: _____ @bw.edu

Address (street, city, state, zip code): _____

_____

By signing below, the student grants OAE permission to contact the provider for additional information.

I, _____ (printed name of student), hereby authorize OAE to obtain and/or release information from/to the undersigned provider in order to evaluate eligibility for academic accommodations.

Student Signature: _____ Date: _____

DIAGNOSTIC INFORMATION (Please Print)

1. Diagnosis(es): _____

_____

_____

2. Date of diagnosis (specify month/year): _____

3. Date of initial contact with the student: _____

4. Date of last contact with the student: _____

5. Frequency of appointments with student (e.g., once per week, once per month): _____

6. What is the severity of the disorder?

☐ Mild ☐ Moderate ☐ Severe

Explain the severity level indicated above: _____

_____

7. Did you use a neurological diagnostic test and/or neuropsychological evaluation to obtain information about the student's symptoms and functioning in various settings?

☐ Yes ☐ No

If yes, specify the neurological diagnostic test and/or neuropsychological evaluation administered and the date completed. *Include a copy of the test/evaluation with the submission of this Verification Form.* _____

_____

_____

If no, how did you reach your conclusion about the neurological disorder diagnosis, symptoms, and treatment? _____

_____

_____

8. What is the expected duration of the impairment? Select one:

☐ Short-term (< 6 months)
☐ Episodic
☐ Long-term (> 6 months – 1 year)
☐ Chronic (> 1 year, frequent recurrence)

Explain the duration indicated above: _____

_____

_____

9. Provide information regarding the student's current presenting symptoms: _____

_____

_____

_____

10. Provide historical information relevant to the student's neurological disorder and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial): _____

11. Does the student currently take medication(s) for neurological disorder symptoms (list medication, dosage, frequency)? If yes, how might side effects impact the student's functioning? _____

12. What are the student's functional limitations, attributable to the neurological disorder? How does the impairment affect the student's performance? _____

13. State specific recommendations regarding reasonable accommodations for this student, and a rationale as to why these accommodations, adjustments, or services are warranted based upon the student's functional limitations. Indicate why each accommodation is necessary: _____

PROVIDER INFORMATION
Print, sign, date and complete all fields below

☐ By selecting this box, I am verifying that the named student information is correct, that the student is a patient that I have been treating, and that **I am not a relative of the student.**

Provider Name (Print): _____ Date: _____

Provider Signature: _____

Title: _____

License or Certification #: _____

Mailing Address: _____

_____

_____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Email: _____

The student signed a Consent for Release of Information on page 1 of this form. We may reach out to you directly for more information or clarification to support the student's request for accommodations.

You may affix a business card in the space below:

Please complete this form in its entirety and submit it to:

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