



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

## Physical Health 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 medical practitioners in the field(s) related to the impairment.
- 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. How did you arrive at your diagnosis? Describe the symptoms that meet the criteria for the diagnosis: \_\_\_\_\_

\_\_\_\_\_

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. Does the student's physical health disorder cause mobility restrictions? If so, explain in detail (e.g., distance student can ambulate without stopping or resting; necessity of elevator versus stairs; methods used to negotiate mobility restrictions): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**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 #: \_\_\_\_\_

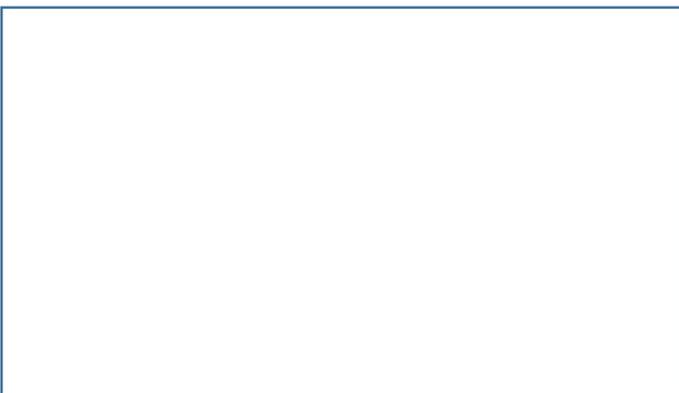
Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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:**

**Baldwin Wallace University  
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