



Disability Services for Students

275 Eastland Road

Berea, Ohio 44017

www.bw.edu/DisabilityServices

Phone: (440) 826-2147

Fax: (440) 826-3832

Email: disability@bw.edu

Neurological Disorder Verification Form

Disability Services for Students (DSS) 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.

DSS 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 www.bw.edu/DisabilityServices.
- The information provided on this form is NOT part of the student’s permanent educational record, but will be maintained with the DSS office.

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 DSS permission to contact the provider for additional information.

I, _____ (printed name of student), hereby authorize DSS 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: _____

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 #: _____

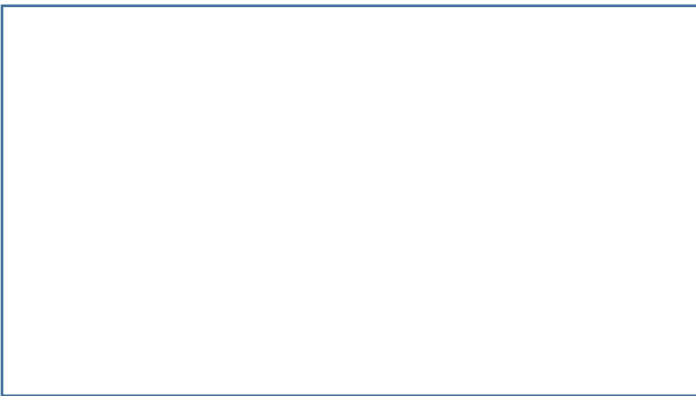
Mailing Address: _____

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
Disability Services for Students
275 Eastland Road
Berea, OH 44017
Fax: (440) 826-3832
Email: disability@bw.edu