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/pulmonologist/ENT.

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):	**With Mitigation (Intervention):**
□Mild	□Mild
□Moderate	□Moderate
□Substantial	□Substantial
□Severe	□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: _____
☐ *By checking this box, I certify that I am not related to the student either by blood or by marriage.*

Date: _____

Please complete and return to:
Associate Dean for Student Affairs
Mercer University School of Medicine
Office of Student Affairs
1550 College Street
Macon, GA 31207
478-301-2652 – office
478-301-5617 – fax (secure)