

Condition Verification Form

Banacos Academic Center's Disability Support Programs

This form is available as a word document online at

<https://www.westfield.ma.edu/academics/academic-support/banacos-academic-center/important-forms-and-documents>

To be completed by student or Banacos advisor.

Student Name: _____ Date of birth: _____

Accommodations requested:

Please reach out to the student's Banacos advisor with any questions about this form.

Banacos advisor: _____

Phone: _____ Email: _____

Written Verification

In order to determine whether we can reasonably provide the above accommodations, we must have written verification from an appropriate practitioner that a learning, medical, physical or psychological condition exists. **The verification should include the following: a diagnosis, the condition's duration, a description of current functional limitations, a description of current symptoms including severity and frequency, and recommendations for accommodations related to campus life (i.e.; academic, housing, or dining).** For learning disabilities, a neuropsychological report is needed and, in many cases, an IEP. This form (or a report with comparable information) must be filled out by an appropriately credentialed practitioner. No student, nor student's family member, may fill out this form.

Please fill in the below information. Be descriptive. More information gives us greater flexibility, especially in cases where a diagnosis has not yet been reached, and may provide reasons to support student needs beyond the accommodations requested above.

Clinician information

Clinician name and credentials:	State Licensure Number or Certification (if applicable):
Agency/Institution:	Address: City, State, Zip
Phone:	Fax:

Diagnosis/Condition/Treatment information

For each diagnosis, please provide the following information. Feel free to copy this section for additional diagnoses.

Diagnosis (*DSM-V where applicable*): _____

Date of Diagnosis: _____

Length of Time Working with Student: _____

Most Recent Evaluation: _____

Expected duration of the condition (*For example, <6 months, chronic, lifetime*): _____

Does this condition substantially limit one or more major life activities? Yes: _____ No: _____

If yes, please list the major life activities here: _____

Describe treatment and medication as needed to demonstrate the student's need for potential adjustments to University policies and practices. *For example, describe the effect of adjusting to new medication or of medication that wears off in the middle of the day as it may affect performance in class.*

Functional Limitations

Please provide a detailed description of how this condition limits the student's life activities listed above in a university setting (housing, dining, academics, internships). Please also include current symptoms, as well as their severity and frequency. More specific examples are helpful, such as: restricted to walking less than 25 feet; experiences panic attacks in testing situations; explanation of visual acuity; exhibits impulsive behavior; using a computer or monitor for more than 20 minutes creates severe headaches, recovery time from seizures, etc. *Please continue on separate page if necessary.*

Symptom	Severity			Frequency
	Mild	Moderate	Severe	

Recommendations

Please provide recommendations for support to address functional limitations due to a condition, treatment, and/or medication. We will use the information to determine the reasonableness of accommodations for the student. *For example: 50-100% extended time on exams to address panic from anxiety; assistance with note taking to help with the processing of information (or to compensate for fatigue, distractibility, poor executive functioning skills, etc.); allowance to stand, move, eat, drink, wear sunglasses, etc. in the classroom; assistive technology; adaptive equipment. As before, feel free to copy the below section for additional conditions or functional limitations.*

Functional limitation and its respective condition: _____
Recommendations: _____

Functional limitation and its respective condition: _____
Recommendations: _____

Functional limitation and its respective condition: _____
Recommendations: _____

Please provide any additional information that would be helpful in determining support for the student. Please continue on separate page if necessary.

Please send in any of the below reports or assessments that are available and relevant to the conditions described above. Check the ones that you will send in.

___ Audiogram/audiology report
___ High School IEP
___ Neuropsychological report
___ Psychoeducational batteries
___ Other _____

Clinician's Signature: _____ **Date:** _____