Medical/Mental Health Verification Form

Hope College Disability Services-Academic Success Center
PO Box 9000
Holland Mi, 49422-9000 Phone # 616-395-7830
Fax # 616-395-7617

Due to the specific nature of a request for accommodation(s), alternate forms or letters may not be accepted and will delay the process.

Please note: Disability Services determines appropriate accommodations. For housing related requests, Housing determines placement based on the approved accommodation.

Part 1 (to be completed by student)

I,_____________________________, hereby authorize the exchange and release of the following confidential information to Hope College Disability Services. The purpose of this disclosure is to determine my eligibility for accommodations based on medical/mental health conditions.

I give consent for Hope College Disability Services to contact my treating professional for additional information as needed. Any such discussion will focus on the condition described on this form only.

I understand that my request for accommodations cannot be addressed until all required documentation is received by Disability Services.

Date:_______________________ Signature:_______________________________________

Student Information:

Last Name:____________________ First Name:__________________M.I.:______________

Student ID #:______________________Phone#:________________D.O.B.______________

Address:____

City:___________________________ State:_____________________Zip:________________

<u>Part II</u> (to be completed by physician, or mental health provider)

Relevant Diagnosis (disability, acute, or chronic medical or psychological condition):_____

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Primary symptoms/behavior addressed in treatment, including date of onset:__________

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Brief History of Presenting Problem:____

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____

Past Treatment:____

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Current Treatment, including specific medication(s), and compliance:________________

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Description of any current functional limitations:_________________________________

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____

Implications in a Residential setting (housing):___________________________________

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____

Implications in the Academic Environment:____________________________________

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____

Implications for campus accessibility:____

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____

Treatment recommendations:____

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____

Licensed Physician/Mental Health Provider (please print)

Name:____

Credentials:____

Address:____

City:______________________________**State:**________________**Zip:**_______________

Phone#:______________________________ **Fax#:**______________________________

License # and State of License:____

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Signature of Licensed Physician/Mental Health Professional:______________________

____

Date:__________________________

Return this completed Medical/Mental Health Verification Form:

Hope College Disability Services Office

PO Box 9000

Holland, Mi. 49422-9000

Fax# 616-395-7617

ds@hope.edu