Medical/Mental Health Verification Form

Hope College Disability and Accessibility Resources
PO Box 9000
Holland Mi, 49422-9000 Phone # 616-395-7925
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:_____

Part II (to be completed by physician, or mental health provider)

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

_____

_____

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

_____

_____

_____

Brief history of presenting problem: _____

_____

_____

Past treatment: _____

_____

_____

Current treatment, including specific medication(s), and compliance: _____

_____

_____

Description of any current functional limitations: _____

_____

_____

Implications in a residential setting (housing):_____

_____

_____

Implications in the academic environment: _____

_____

_____

Implications for campus accessibility: _____

_____

_____

Licensed Physician/Mental Health Provider (please print)

Name:_____

Credentials:_____

Address:_____

City:_____State:_____Zip:_____

Phone#:_____ Fax#:_____

License # and State of License:_____

_____

Signature of Licensed Physician/Mental Health Professional:_____

_____

Date:_____

Return this completed Medical/Mental Health Verification Form:

Hope College Disability and Accessibility Resources | Fax# 616-395-7617 | dar@hope.edu