MOREHOUSE SCHOOL OF MEDICINE | Office of Inclusive Learning and Accessibility Services

VERIFICATION OF DISABILITY CHECKLIST

This is ONLY a guide for providers to understand the requirements that should be embedded in the provider's recommendation letter!

Purpose: 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 review this form in its entirety and be as detailed as possible.

Disability Category and Requested documentation:

- **Chronic Health Conditions** other than those listed below - this form should be completed and signed by an appropriate licensed medical specialist (MD/DO/NP/PA).
- **Psychological Disabilities** other than ADD/ADHD - this form must be dated within one year and completed and signed by a licensed counselor, therapist, psychologist or psychiatrist (mental healthcare professional).
- **ADD/ADHD -** attach a comprehensive Psychological Evaluation dated within 3 years and signed by a licensed psychologist or this form must be dated within one year by treating healthcare provider.
- **Learning Disabilities** - attach a comprehensive Psychological Evaluation Report with subtest scores, dated within 3 years and signed by a licensed psychologist.
- **Hearing Impairment or Deaf** - complete and attach the most recent audiogram dated within one year. Form and Audiogram must be signed by a licensed audiologist.
- **Visual Impairment or Deaf** - attach recent acuity and field of vision dated within 3 years. Form and Vision assessment must be signed by an ophthalmologist.
- **Allergies or Asthma**– If allergies, attach allergy results dated within 3 years. Form and Test results must be signed by an allergist or pulmonologist.
- **Physical Disabilities**-attach the most recent Physical Evaluation Report dated within one year. Form and Evaluation must be signed by a license PMR, PT, OT, etc.

For Any Disability, Additional or More Recent Documentation May Be Required

- Learner's Name:
- Degree Program
- DSM-V-TR
- Onset of Condition(s)
- Date of Last Visit for Condition:
- Current Status (e.g. Active, Progressing, Controlled, In Remission)
- **Attendance, Participation, Clinical Activities, Student Teaching etc:**
  - Please describe the impact that the student's condition will have on his/her ability to attend or participate in classes, clinical activities, student teaching etc:
- **Functional Limitations:** What are the student's current functional limitations (again, be as specific and detailed as possible and provide information for all disability areas)

Recommended Accommodations:

Identify any accommodations you believe may be **necessary** in order for the student to participate in the University's programs, activities and services (please be specific, For example if you are recommending a learner be given breaks during examinations and/or class time, please quantify the times in the provider's letter: 2- ten minute breaks every 60 minutes)

- Name of Treating Healthcare Professional:
- Specialty:
- License # and State:
- Address:
- Telephone:

- Signature (**verifying that you are not related to the student by blood or marriage**

All documentation should be submitted by the provider and NOT the learner. Providers should email all supporting medical documentation to the Office of Inclusive Learning and Accessibility Services @oilas@msm.edu with the subject being the learner's full name from HIPPA a secured email account.

If you have any questions, please do not hesitate to contact our office **(@oilas@msm.edu**). All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). Thank you for your assistance.