Services for Students with Disabilities (SSD)
117 Louise Pound Hall
P.O. Box 880335
Lincoln, NE 68588-0335

Phone: (402) 472-3787
Fax: (402) 472-0080

VERIFICATION FORM FOR CHRONIC HEALTH DISABILITIES

The University of Nebraska Lincoln (UNL) is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equal access to the University's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a chronic health condition, in and of itself, does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

The Office of Services for Students with Disabilities (SSD) strives to insure that qualified students with Chronic Health Disabilities are accommodated and, if possible, that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to an Chronic Health Disability should have this form filled out by a doctor, physician's assistant or nurse. The professional completing this form must have first-hand knowledge of the student's condition, must have experience diagnosing and treating college students, and will be an impartial professional who is not related to the student.

This form is not the only part of this process. Equally and sometimes more important will be your interview with SSD staff. Ideally this would happen before you begin attending class.

Student Information *(This section to be completed by the student)*

Last Name First Name Middle Initial

ID Number Date of Birth

Address

City State Zip Code

Certifying Professional

Name Credentials

Address

City State Zip Code

License/Certification number and state of licensure

Years of experience working with college students

Date of initial contact with student Date of last contact with student

Please provide diagnosis/diagnoses and their corresponding dates below.

Basis on which diagnosis was made

Current medications including dosage and side effects

Long term medication plan

Current compliance with medication plan

Prognosis for medication plan (Include likelihood of improvement or further deterioration and within what approximate time frame)

Other planned therapeutic interventions

Prognosis for therapeutic interventions (Include likelihood for improvement or further deterioration and within what approximate time frame)

Current compliance with therapeutic interventions

History of hospitalization

Implications for Educational Success

Learning abilities specific to the postsecondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc.)

Implications for taking exams and other classroom activities caused by the disorder or medications. Please specify which

Suggested accommodations (Final determination of appropriate accommodations will be determined by the SSD office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws). Each recommended accommodation should be accompanied by an explanation of its relevance to the disability that is diagnosed.

If you have any questions regarding the nature of the information needed for students with psychiatric impairments, please call Services for Students with Disabilities at **(402) 472-3787, Monday through Friday from 8:00 A.M. to 5:00 P.M.** Central Standard Time.

This form should be returned to **117 Louise Pound Hall, P.O. Box 880335, Lincoln, NE 68588-0335** or faxed to us at **(402) 472-0080**.

This document may not be released without written permission from the student or by order of a court. It will be destroyed three years after the student is no longer enrolled. The student will have access to this document but you may specify that this access be given when there is a person qualified to explain the document available.

Signature of Certifying Professional _____ **Date** _____

Signature Required