JOHNS HOPKINS
SCHOOL of NURSING

Disability Verification Form
To be completed by the individual's provider

INFORMATION AND INSTRUCTIONS

Please note - this form is not to be used for students with a Cognitive Disability. For instructions about required documentation, please visit http://oie.jhu.edu/ada-compliance/documentation-guidelines/

In order for us to provide disability-related services, we need to establish that this individual has a physical or mental impairment that limits one or more of the major life activities and the impact on essential functions. This form is designed to help us make that determination. Documentation guidelines are available at http://accessibility.jhu.edu/accommodations/.

Note: *The diagnosing professional must have expertise in the differential diagnosis of the documented disorder or condition, must follow established best-practices in the field, and must not be related to the patient.*

Providers: Please fax this form to:

(410) 367-2775

SDS Services
Student Affairs Office
525 N. Wolfe Street
Baltimore, MD 21205
Phone: (410) 955-7545
Email: SON-SDS@jhu.edu

OR

Students:

Please upload this form to your Accommodate record.

JOHNS HOPKINS
SCHOOL of NURSING

Disability Verification Form
To be completed by the individual's provider

Today's Date: _____

Individual's Name: _____

JHU School: _____

DIAGNOSIS:

_____

_____

How did you arrive at your diagnosis? Please check all relevant items below:

Structured or unstructured interviews	☐	Medical tests	☐
Interviews with other persons	☐	Medical history	☐
Behavioral observations	☐	Developmental history	☐

Please briefly describe, as appropriate, the history of presenting symptoms and past functioning, duration of the disorder, relevant development, historical and familial data.

_____

_____

_____

HISTORY AND PROGNOSIS					Other
Date condition was first diagnosed	_____				_____
Date individual first seen for	_____				_____
Date most recently seen for condition	_____				_____
Expected duration of condition	_____			Permanent ☐	_____
How long do you anticipate the impact	3M ☐	6-12M ☐	12M ☐	More than 12M ☐	_____
Anticipated return to work date	_____			TBD at a later date ☐	_____
The condition is	Stable ☐	Improving ☐	Worsening ☐	Cyclically variable ☐	_____
The prognosis is	Poor ☐	Fair ☐	Good ☐	Excellent ☐	_____
How often is this individual seen	Weekly ☐	Monthly ☐	3-6 mos ☐	Yearly ☐	_____

Is the individual currently taking medication(s) for this issue? YES☐ NO☐

If yes, what medications is the individual currently taking? For each medication, describe the side effects and any impact on performance. Do limitations/symptoms persist even with medications? Please list on the following page.

Medication and Dosage	Side Effects	Academic/Work Impact	Persistence of Symptoms (Y/N)

Which specific symptoms currently manifesting themselves might affect the individual's ability to do essential functions?

_____

_____

_____

Please check which areas listed below the individual is functionally limited in because of the medical diagnosis and/or the medication. Please indicate the level of limitation using the following scale.

1 = Unable to Determine | 2 = No Impact | 3 = Mild Impact | 4 = Moderate Impact | 5 = Substantial Impact

Major Life Activities	**1**	**2**	**3**	**4**	**5**		**Learning/Time Management**	**1**	**2**	**3**	**4**	**5**
Caring for Oneself	☐	☐	☐	☐	☐		Memory	☐	☐	☐	☐	☐
Talking	☐	☐	☐	☐	☐		Concentrating	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐		Listening	☐	☐	☐	☐	☐
Breathing	☐	☐	☐	☐	☐		Organization	☐	☐	☐	☐	☐
Seeing	☐	☐	☐	☐	☐		Managing distractions	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐		Timely submission of assignments	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐		Attending class regularly	☐	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐	☐		Making and keeping appointments	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐		Managing stress	☐	☐	☐	☐	☐
Performing Manual tasks	☐	☐	☐	☐	☐		Reading	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐		Writing	☐	☐	☐	☐	☐
Working	☐	☐	☐	☐	☐		Spelling	☐	☐	☐	☐	☐
Interacting with others	☐	☐	☐	☐	☐		Quantitative reasoning (math)	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐		Processing Speed	☐	☐	☐	☐	☐

Does the impairment substantially limit the operation of a major bodily function? Yes ☐ No ☐
If yes, please describe what bodily functions are affected.

_____

_____

_____

Please list any specific accommodations or services to address any functional limitations above.

_____

_____

_____

Have there been any changes in the individual's condition in the past 12 months?

NO ☐ YES ☐ Please explain.

_____

_____

_____

Do you anticipate any changes in the individual's condition/medication in the next 12 months?

NO ☐ YES ☐ Please explain.

_____

_____

_____

Is the individual working with another provider or specialist to treat the condition(s)?

NO ☐ YES ☐ Please explain.

_____

_____

_____

Is there anything else you think we should know about the individual's medical condition?

_____

_____

_____

PLEASE TYPE OR PRINT CLEARLY

Name/Title _____

Signature _____ Date: _____

License/Certification #_____ State _____

Address _____

City, State, Zip Code_____

Phone _____

Fax _____