

# 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: All requests are reviewed on a case by case basis and accommodations are determined through an interactive process with the student. The purpose of an accommodation is to provide access to the same information, interactions and services as all other students. A medical diagnosis alone and a recommendation for a specific accommodation may not establish an associated need for accommodations. Determinations are made by connecting functional limitations associated with a disability and the mitigating effect of the accommodation and these can vary greatly among individuals with the same diagnosed condition.

Part 1 (to be completed by student)

g professional for  
e condition described in

d until all required

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## Student Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Student ID #: \_\_\_\_\_ Phone#: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Part II (to be completed by physician, or mental health provider) Diagnoses of disabilities documented by family members are not accepted.

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. Functional limitations are restrictions in the ability to perform an action/activity or the way in which a condition limits or impacts a person.

Please include specific restrictions for physical activity if applicable.

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Implications in the academic environment: \_\_\_\_\_

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Implications for campus accessibility: \_\_\_\_\_

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Implications in a residential setting (housing): \_\_\_\_\_

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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 to:

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