Accessibility Resources & Services
550 North College Avenue
Claremont, CA 91711
Office: 909.621.8017|Fax: 909.607.7288
Email: Disability@pomona.edu

DISABILITY VERIFICATION FORM

The student named below is requesting accommodations on the basis of a disability at Pomona College. To determine eligiblity for services, we require current and comprehensive documentaion of their diagnosed condition resulting in impairment to functional abilities. The information provided here is confidential and will not become part of the patient's educational records. Please write legibly and fill out entirely to avoid any delays.

SECTION 1: STUDENT INFORMATION

STUDENT NAME: _____ ID:_____ BIRTHDATE (MM/DD/YYYY): _____

SECTION 2: DIAGNOSTIC INFORMATION

1. DIAGNOSIS: _____ DSM/ICD CODE: _____

ONSET DATE: _____ SEVERITY: ☐MILD ☐MODERATE ☐SEVERE ☐ IN REMISSION

ANTICIPATED DURATION: ☐ CHRONIC/PERMANENT ☐ TEMPORARY; EXPECTED TO LAST: _____

2. DIAGNOSIS: _____ DSM/ICD CODE: _____

ONSET DATE: _____ SEVERITY: ☐MILD ☐MODERATE ☐SEVERE ☐ IN REMISSION

ANTICIPATED DURATION: ☐ CHRONIC/PERMANENT ☐ TEMPORARY; EXPECTED TO LAST: _____

SECTION 3: TREATMENT HISTORY

DATE YOU FIRST TREATED THE STUDENT FOR THIS CONDITION: _____

LIST THE DATES YOU HAVE TREATED THIS PATIENT FOR THE PAST 12 MONTHS? _____

IS THERE A HISTORY OF HOSPITALIZATION FOR THIS CONDITION? PROVIDE DATE(S) _____

CURRENT TREATMENT PLAN/ FOCUS OF CLINICAL TREATMENT: _____

_____

CURRENTLY PRESCRIBED MEDICATION(S): (INCLUDE CURRENT DOSAGE):_____

_____

_____

SECTION 4: DISABILITY INFORMATION

PLEASE IDENTIFY THE SYMPTOMS CAUSED BY THE DISABILITY AND HOW THEY SUBSTANTIALLY LIMIT ONE OR MORE MAJOR LIFE ACTIVITIES FOR THE STUDENT:

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Major life activities assessment: Please indicate which activities of daily life are affected due to their impairment	**Indicate Severity of Impairment** *(Mild, Moderate, Severe, Extreme/Cannot Do)*
Talking	
Hearing	
Breathing	
Standing	
Caring for oneself	
Reaching	
Lifting	
Sitting	
Walking	
Seeing	
Writing	
Performing Manual Tasks	
Sleeping	
Learning	
Reading	
Thinking	
Concentrating	
Memorizing	
Interaction with others	
Other	

SECTION 5: RECOMMENDED ACCOMMODATIONS

A request for accommodation should be accompanied with a clear rationale for its necessity. Documentation should establish a clear link between the requested accommodation and the functional limitation it seeks to alleviate.

_____

_____

_____

SECTION 6: PROFESSIONAL CERTIFICATION

By signing below, I am certifying that I am a health care provider who is authorized to practice by the state and performing within the scope of my practice as defined by State laws (29 CFR § 825.125 and AB-468). I also verify that the information is current and accurate to the best of my knowledge based on my recent evaluation of this patient and/or my review of records.

_____ _____
PROVIDER'S NAME PROVIDER'S SIGNATURE

_____ _____
PROFESSIONAL TITLE, CREDENTIALS, AREA OF SPECIALIZATION LICENSE NUMBER

_____
STREET ADDRESS CITY STATE ZIP

( ) _____ _____
PHONE EMAIL TODAY'S DATE