



**DISABILITY VERIFICATION**  
**Medical Condition/Chronic Health Disabilities**

***Please read the following prior to completing this form:***

The Center for Student Success at Malone University provides support services to students with diagnosed disabilities, including serious medical conditions and chronic health disabilities. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires current and comprehensive documentation of the disorder from their diagnosing/current physician. This should include information that describes the symptoms and manifestations of the condition, medication prescribed, and recommendations for treatment.

Please note that eligibility for services is determined based on a review of this information, in accordance with criteria established in the codification of *Section 504 of the Rehabilitation Act of 1973*, and in cases pertaining to the *Americans with Disabilities Act*. It is therefore imperative that comprehensive information be provided so that Malone University can make an appropriate determination about the student's eligibility to receive disability-related accommodations under the law.

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Please provide the following information about: \_\_\_\_\_

1. Diagnosis: \_\_\_\_\_  
Date of Diagnosis: \_\_\_\_\_  
Last contact with student: \_\_\_\_\_

2. Describe the symptoms associated with this medical condition and the student's prognosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Describe how this medical condition **substantially limits a major life activity** and **how it may impact the student/patient's progress** in an academic setting: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. List current medication, dosage, frequency and possible adverse side effects: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. List other treatment the student is receiving to manage his/her condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. List any recommendations for accommodations in an academic setting that you have for this student (i.e. extra time on tests, different type of chair, lighting, residence hall room/furniture modification, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Describe any specific concerns you may have, or other ways that we may be of further assistance to this student: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Printed Name and Title: \_\_\_\_\_

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

Phone: (       ) \_\_\_\_\_

The information you provide in this document is maintained in the Office of Student Accessibility Services at Malone University according to the guidelines of the Family Education Rights and Privacy Act (FERPA).

**Please mail or fax this form to:**  
Center for Student Success  
Malone University  
2600 Cleveland Ave. NW  
Canton, OH 44709  
Phone: 330/471-8496  
Fax: 330/471-8390