



MALONE UNIVERSITY

CHRIST'S KINGDOM FIRST

DISABILITY VERIFICATION
Physical/Orthopedic Disabilities
(to be completed by diagnosing or current physician)

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 physical and orthopedic 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 onset of the disability, its manifestations, and recommendations for accommodations in an academic setting.

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. Confidentiality of the information provided is ensured, and will in no way become part of the student's academic record. Please feel free to contact the Office of Student Accessibility Services with any questions or concerns you might have regarding the information you are being asked to provide. Thank you for your assistance.

Please provide the following information about: _____

1. Diagnosis: _____

Date of Diagnosis: _____

Last contact with student: _____

2. Describe the physical limitations associated with this disability and the student's prognosis:

3. Describe how this physical condition will likely impact the student's progress in the college environment: _____

(OVER)

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

5. List any other treatment the student is receiving to manage his/her disability: _____

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: _____

Physician Signature: _____ Date: _____

Printed Name and Title: _____

Address: _____

Phone: () _____

E-mail address (if applicable): _____

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