OFFICE OF ACCESSIBILITY SERVICES
CENTRAL

Medical Verification Form

PAGE 1 TO BE COMPLETED BY STUDENT

The purpose of this Medical Verification Form is to obtain relevant medical and/or psychiatric information from a qualified licensed medical professional about a student who is requesting accommodations at Central Connecticut State University. In accordance with applicable state and federal laws and to ensure an equitable and inclusive environment, this information will be used by the Office of Accessibility Services to determine eligibility for accommodations and will be vital in the determination of reasonable accommodations at the university level.

CONFIDENTIALITY STATEMENT

The Office of Accessibility Services (OAS) maintains the confidentiality of student records to the extent required and permitted by law. Documentation that is received by OAS is protected under the Family Educational Rights and Privacy Act of 1974 (FERPA), a federal law that regulates the disclosure of disability documentation and records maintained by OAS. Any disability documentation or records provided to OAS become part of the student's educational record under FERPA and will only be released from the file with the student's written consent or in the case of a court order or medical emergency. Under FERPA, OAS staff may also release pertinent information about the impact of a student's disability to any school official who has a "legitimate educational interest" when appropriate and will carefully balance it with a student's right to confidentiality.

STUDENT INFORMATION

Full Name _____
First **Middle** **Last**

Date of Birth _____ **Student ID** _____

Indicate accommodations you are seeking

_____ _____
Academic - list type(s) ***Housing - list type(s)***

Semester and year you want accommodations to begin ***i.e Fall 2024*** _____

CONSENT TO RELEASE MEDICAL AND/OR PSYCHIATRIC INFORMATION CONTAINED WITHIN THIS FORM TO THE OFFICE OF ACCESSIBILITY SERVICES AT CENTRAL CONNECTICUT STATE UNIVERSITY

I authorize the licensed medical professional listed below to complete this form in its entirety for the purpose of providing pertinent medical information vital in the determination of eligibility for and reasonableness of accommodations I am seeking while attending CCSU. I understand that the Office of Accessibility Services Staff may request additional information. Furthermore, I give my consent for the Accessibility Services Office to contact the professional completing this form for additional information as needed.

_____ _____
Name of Provider **Name of Clinic/Facility**

_____
Address **Speciality** **Phone Number**

I certify that I fully read and understand the statement indicated above:

_____
Printed Name of Student **Signature of Student** **Date**

PAGES 2-5 MUST BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL WHO IS QUALIFIED TO DIAGNOSE AND TREAT THE CONDITIONS NOTED HEREIN AND HAS ESTABLISHED A PATIENT-PROVIDER RELATIONSHIP WITH THE STUDENT

MEDICAL/PSYCHIATRIC INFORMATION

Please Note: A diagnosis alone is insufficient to determine eligibility for and/or reasonableness of accommodations. Please carefully complete all fields as applicable and be as specific as possible to avoid processing delays.

Primary Diagnosis _____ **DSM-5 or ICD-10 Code** _____

Date of Diagnosis _____ **Severity** **Mild** ☐ **Moderate** ☐ **Severe** ☐

Method/diagnostic tests and/or criteria used to determine diagnosis

_____

Duration **Temporary (0-6 months)** ☐ **Permanent/Chronic** ☐ **Frequency** **Episodic** ☐ **Persistent** ☐

Secondary Diagnosis _____ **DSM-5 or ICD-10 Code** _____

Date of Diagnosis _____ **Severity** **Mild** ☐ **Moderate** ☐ **Severe** ☐

Method/diagnostic tests and/or criteria used to determine diagnosis

_____

Duration **Temporary (0-6 months)** ☐ **Permanent/Chronic** ☐ **Frequency** **Episodic** ☐ **Persistent** ☐

Tertiary Diagnosis _____ **DSM-5 or ICD-10 Code** _____

Date of Diagnosis _____ **Severity** **Mild** ☐ **Moderate** ☐ **Severe** ☐

Method/diagnostic tests and/or criteria used to determine diagnosis

_____

Duration **Temporary (0-6 months)** ☐ **Permanent/Chronic** ☐ **Frequency** **Episodic** ☐ **Persistent** ☐

ACADEMIC ACCOMMODATIONS

Please Note: If student is seeking academic accommodations, please complete this section in its entirety. If not skip to the next section

Please provide a detailed description of the symptoms the student experiences in an academic environment that are related to the conditions listed on page 2.

Specify the level of impact these symptoms have on the student's ability to function in an academic environment.

No Impact ☐ **Mild Impact** ☐ **Moderate Impact** ☐ **Severe Impact** ☐

HOUSING ACCOMMODATIONS

Please Note: If student is seeking housing accommodations, please complete this section in its entirety. If not skip to next section

Please provide a detailed description of the symptoms the student experiences in a residential environment that are related to the conditions above. Consider the impact of the conditions/ symptoms when sharing a room with others.

Please Note: If student is seeking an Emotional Support Animal, please complete this section in its entirety. If not skip to the next section

Type of animal (breed, name, age if applicable)

Date in which ESA was deemed to be an appropriate mental health treatment

Rationale utilized to determine need for ESA

Indicate specifically how the housing accommodation(s) would alleviate symptoms and or mitigate the impact of the condition(s) on the student's residential experience.

If the requested accommodation were not available or granted, please indicate the impact this would have on the student's functioning in a shared residential environment and the rationale for your determination.

Specify the level of impact these symptoms have on the student's ability to function in a residential environment.

No Impact ☐	Mild Impact ☐	Moderate Impact ☐	Severe Impact ☐

Based upon the students requested housing accommodation(s) listed on page one, please indicate the level of medical necessity for each accommodation

Accommodation Type	Level of Medical Necessity *Check one*	Accommodation Type	Level of Medical Necessity *Check one*
	Low/Moderate ☐ High/Severe ☐		Low/Moderate ☐ High/Severe ☐
Accommodation Type	**Level of Medical Necessity** *Check one*	**Accommodation Type**	**Level of Medical Necessity** *Check one*
	Low/Moderate ☐ High/Severe ☐		Low/Moderate ☐ High/Severe ☐

Please indicate any additional information that may assist in the exploration of reasonable accommodations.

HEALTH CARE PROVIDER INFORMATION

Printed Name & Title	
Area of Expertise/Specialty	

(i.e. PCP, Psychiatrist, Psychologist, Psychotherapist, Neurologist)

Address	
Phone Number	
Email Address	

☐ **I confirm that I am not related to the student through blood, marriage or other legal arrangement**

I certify that the information provided herein is true and correct to the best of my knowledge and belief:

Signature of Provider	

For questions, contact us directly at 860.832.1952
Thank you

RETURN TO

Address	**Accessibility Services** **Central Connecticut State University** **Willard Hall, Suite W201** **1615 Stanley Street PO Box. 4010** **New Britain, CT 06050-4010**
Fax Number	**860.832.1865**
Email Address	**accessibilityservices@ccsu.edu**