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Office of Accessibility Services (OAS)

Medical Verification Form

Franklin University recognizes the needs of students with disabilities and is committed to providing accessible services, programs, and educational opportunities. In addition to accessible facilities, the Office of Accessibility Services (OAS) is available to provide reasonable accommodations, guidance, and additional resources. The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility.

Please take note of the following as you complete this form:

- **The person completing this form should be a healthcare professional who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is a part of the student's treatment plan for a previously diagnosed condition.** These professionals are generally trained, certified, or licensed to diagnose and/or treat medical conditions. Examples include: psychiatrist, psychologist, therapist, social worker, medical doctor, optometrist, speech-language pathologist.

- **Please complete all parts of this form as thoroughly as possible.** Inadequate information, illegible handwriting, or missing fields may delay the eligibility review process by necessitating follow up contact for clarification.

- Please feel free to attach to this form any other documents or information you think would be relevant in determining the student's academic accommodations.

- The information you provide will be kept in the student's file with Accessibility Services, where it will be held securely and confidentially.

Once completed, please email back to the student so that they can save this form to add as an attachment to their OAS application.

If you have questions regarding this form, please call 614-797-4700 or email accommodate@franklin.edu.

Thank you for your assistance.

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Student Information

(Please Print Legibly or Type)

First Name **M.I.** **Last Name**

Date of Birth **Student ID #**

Cell Phone **Alternate Phone**

Franklin email address @email.franklin.edu

Alternate email address

Healthcare Provider Information

(Please fill in **ALL** fields)

Provider Name (print)

Title

Phone Number

Fax Number

Provider Signature **Date**

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Diagnostic Information

Date of Diagnosis:

Primary Diagnosis:

Secondary Diagnosis (if applicable):

Is the listed condition

☐ **Permanent**

☐ **Temporary (lasting longer than a week)**

- Please provide additional details on timeframe of temporary diagnosis.

Other Diagnoses:

What is the severity of this disorder?

☐ **Mild**

☐ **Moderate**

☐ **Severe**

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- **Please describe how the student's disability, symptoms of, or treatment plan – including medications- currently impacts their learning in an academic setting.**