FRANKLIN UNIVERSITY
Otte Center for Student Services
201 S. Grant Ave
Columbus, OH 43215

OFFICE OF DISABILITY SERVICES
Phone: 614.797.4700
Fax: 614.255.9518

accommodate@franklin.edu

Verification of Physical Condition and/or Chronic Medical Condition

The Office of Disability Services at Franklin University provides services and/or accommodations for students with disabilities intended to facilitate equal access to educational opportunities. To determine eligibility for services and/or accommodations, current and comprehensive documentation regarding a physical or mental condition and its impact on the student's functioning is required from a licensed medical professional qualified to diagnose and treat the particular condition(s).

Authorization to Release Medical Information/Records

Due to my medical condition, I have requested course, classroom, and/or testing accommodations from Franklin University. The primary purpose of this authorization is to provide medical documentation to establish the required accommodations.

I AUTHORIZE the release of medical information/records concerning me to the Office of Disability Services at Franklin University.

I AUTHORIZE all qualified healthcare professionals who have treated me to discuss my care and treatment they have provided to the staff of the Office of Disability Services at Franklin University.

I UNDERSTAND that by requesting this information, I am waiving my rights to physician/patient confidentiality for which I am entitled.

I UNDERSTAND that the medical information that I have authorized for disclosure is confidential and will not be released without my permission, except to staff in the Office of Disability Services at Franklin University.

I have read and understand the terms of this authorization.

SIGNATURE		**PRINT NAME**	
DATE			

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Verification of Physical Condition and/or Chronic Medical Condition

The student named below is requesting disability-related academic accommodations from Franklin University. Students requesting accommodations should provide sufficient evidence of their condition so that the University can (1) verify the existence of a condition or disability; (2) determine if the disability impact major life activities; (3) discuss appropriate accommodations with the student.

Required documentation must be completed by a qualified health care professional whom has first-hand knowledge of the student's condition, experience working with students with the specific condition, and familiarity with students in an academic setting.

Current and sufficient documentation is required to assist in determining the appropriate accommodations. Additional documentation may be required.

All documentation is confidential and should be submitted to the below address.

Franklin University
Office of Disability Services
201 South Grant Avenue
Columbus, Ohio 43215
877-341-6300 (toll free) 614-255-9518 (fax) 614-947-6753 (local)

HEALTHCARE PROVIDER INFORMATION

PRINT NAME		TITLE	
LICENSE NUMBER			
ADDRESS			
PHONE NUMBER			

STUDENT INFORMATION

NAME OF STUDENT			
DATE OF BIRTH		DATE OF LAST CONTACT	
DIAGNOSIS		DATE OF DIAGNOSIS	

IS THIS A TEMPORARY OR PERMANENT CONDITION? ☐ Temporary ☐ Permanent

MAJOR LIFE ACTIVITIES IMPACTED

Below is a checklist of the major life activities that could be impacted by a physical disability or a chronic medical condition. Please check all that apply, indicating the severity of impact.

Major Life Activity	No Impact	Mild Impact	Moderate Impact	Substantial Impact
Talking	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Breathing	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Reaching	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Seeing	☐	☐	☐	☐
Writing	☐	☐	☐	☐
Performing Manual Tasks	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Memorizing	☐	☐	☐	☐
Interacting with Others	☐	☐	☐	☐

How might this condition substantially limit the student's functioning in a university academic setting (e.g., unable to concentrate or sit for long periods of time, walk certain distances without fatigue, breaks to attend to symptoms or take medication, etc.)?

Please list any current medication, dosage, frequency, and side effects that may affect the student's academic performance:

What are your recommendations for reasonable accommodations or auxiliary aids? Please provide a rationale based upon the functional limitations of this student in an academic setting.

I certify that I have completed this form accurately and to the best of my ability.

Signature		**Date**	