



**Virginia State University
Student Accessibility Office
Provider Verification Form**

To ensure your request for an accommodation is considered, please submit a completed application. This form may be used for all accommodation requests, including academic, housing, ESA, dietary, etc.

- If your request is for a **housing accommodation**, you must complete an application for housing. Please follow the specific process outlined by the Department of Residence Life and Housing.
- Applicants requesting accommodation for a Service Animal, **STOP** here and contact the Student Accessibility Office for detailed procedures and required documentation.

Note: Accommodations are determined on a case-by-case basis and are not automatically guaranteed based on the recommendation.

To be completed by the student

| | |
|-----------------|--------------------------|
| Student's Name: | Student's email address: |
| V#: | Student's phone number: |

Type of Accommodation(s) Requested (Select all that apply):

| | | | |
|-----------------------------------|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> Academic | <input type="checkbox"/> Housing | <input type="checkbox"/> Emotional Support Animal | <input type="checkbox"/> Dietary |
|-----------------------------------|----------------------------------|--|----------------------------------|

To be completed by licensed medical/mental health provider

We appreciate your partnership in supporting our students' accessibility needs. To ensure each student receives the appropriate accommodation, it's crucial that the information you provide is as thorough and detailed as possible. Thank you for your careful attention and support.

Name of Practice: _____

Physician/Provider Name: _____

Title: _____

NPI#: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Diagnosis of Medical Condition(s), Psychological Disorder (s) or Primary Disability List:

Original date of diagnosis/diagnose:

Length of time treating patient:

Date of most recent treatment or diagnosis/diagnoses:

List medication used for treatment of the condition(s):

Explain any side effects from the medication:

Prognosis for Diagnosis/Diagnoses:

- Permanent/Chronic 6-12 months 6 months or less Episodic

Severity of the Condition:

- Mild Moderate Severe

Please provide detailed information concerning the nature and extent of the disability:

Provide specific information on the functional limitation as relates to the accommodation recommended:

Describe the current course of treatment by the provider (please provide frequency and duration):

Please provide the prognosis for the disability:

In the space provided, please address the following:

Please list any accommodations you recommend for the student and give justification for EACH recommendation. (If applying for a housing accommodation be specific in sharing how the accommodation(s) or modification(s) is medically necessary/required for the student to have equal access to the residence hall; and, in the case of an Emotional Support Animal request, describe how the animal has been utilized as a part of your current treatment plan with the student. Additional space is provided at the end of the document.)

What other alternative to accommodations could satisfy as reasonable accommodations?

Please check which of the following major life activities is substantially limited by the disability:

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Eating | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> Use of bodily functions |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Speaking | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Breathing | <input type="checkbox"/> Thinking |
| <input type="checkbox"/> Working | <input type="checkbox"/> Organizing information | <input type="checkbox"/> Other: |

Other:

Is there anything else you think we should know about the student's medical condition and their ability to function?

Signature below certifies that the information provided is accurate and that records for this student are on file and the physician/provider will be available for clarification upon request.

X

Signature

Date

