



Verification of Medical Disability

Blind/Visual Impairment, Deaf/Hearing Impairment,
Physical Disability, Mobility Impairment, or
Chronic Health Condition

Office of Disability Services
P.O. Box 5005
Ashland, VA 23005
Phone: (804) 752-3152
Fax: (804) 752-3744
Email: dss@rmc.edu

Qualified Professional Statement

Today's Date: _____

Student Name: _____

The above-named student is requesting accommodation(s) due to their medical condition under the Americans with Disabilities Act. In order to consider this request, as well as to ensure the provision of reasonable and appropriate accommodations, the College requests that current and comprehensive verification be provided by a qualified professional. The qualified professional should be a licensed or otherwise properly credentialed individual who has undergone appropriate and comprehensive training, has relevant experience, and has no personal relationship with the individual being evaluated. The individual making the diagnosis should have credentials directly related to the condition being reported (e.g., an orthopedic limitation should be documented by a physician, not a licensed psychologist).

To facilitate the gathering of such critical information, please respond to the following questions, attach any appropriate diagnostic reports, and return to Randolph-Macon College, Office of Disability Services.

Please provide the following information:

Clearly state the diagnosed disability or condition (include specific DSM-V/ICD-10 diagnosis as appropriate):

Date of diagnosis: _____

Date of last contact with student: _____

Prognosis, if applicable: _____

How long has the student been under your care for this condition?: _____

Treatments, medications, assistive devices/services currently prescribed or used:

Describe diagnostic criteria, evaluation methods, tests and dates of administration (e.g., physical findings, x-rays, lab tests):

Describe the current functional limitations resulting from the disability or condition (i.e., provide a clear sense of the severity and/or frequency and how the condition will impact the student in the educational/residential setting):

Describe restrictions, if any: _____

Expected date restrictions will be lifted, if any: _____

Describe what, if any, accommodations are recommended to support this students' needs. These recommendations should logically relate and support the functional limitations in a classroom or residential setting.

Professional's Signature: _____ **Date:** _____

Printed Name and Title: _____

License #: _____

Address: _____

Daytime Telephone Number: (_____) _____

Return this verification form and any supplemental information to:

Randolph-Macon College
Higgins Academic Center
Office of Disability Services
P.O. Box 5005
Ashland, VA 23005

Phone: 804-752-3152
Fax: 804-752-3744
Email: dss@rmc.edu

Office of Disability Services (DS) will use the information on this form to determine the student's eligibility for disability services. DS is committed to ensuring that all information and communication pertaining to a student's disability be kept confidential as required by law.