



LA ROCHE
UNIVERSITY

Engaging Minds. Embracing the World.

Verification Form for Accessibility Services

The student named below may be eligible for reasonable accommodations at La Roche University. In order to provide services, we must have documentation of a disability or medical condition that impairs one or more major life functions. This form may be submitted to the Coordinator of Accessibility and Compliance via fax at 412-536-1118 or mailed to La Roche University, Office of Accessibility Services, 9000 Babcock Blvd., Pittsburgh, PA 15237.

TO BE COMPLETED BY THE STUDENT: *(Please print)*

Student Name _____ Phone Number _____

Address _____

La Roche University Email _____

I hereby authorize the provider listed below to complete this form and provide information to La Roche University pertaining to my disability and/or medical condition.

Student signature _____ Date _____

TO BE COMPLETED BY A LICENSED PROFESSIONAL: *(Please print)*

Name of provider (please print) _____ Phone Number _____

This portion of the form is to be completed by a licensed professional qualified to make the diagnosis for which the student is seeking accommodation. It cannot be completed by any family member of the student. **Please provide the following information in full (please be specific). *This form is not valid unless there is a diagnostic statement given, a description of the disability/medical condition is provided, functional limitations are listed, and it is signed and dated in the appropriate place.***

Diagnostic statement _____

Description of the disability/medical condition:

For psychiatric conditions, DSM-5 diagnosis or succeeding equivalent:

In what settings or on what academic tasks will this disability/medical condition likely manifest itself?

Please list the functional limitations associated with this disability/medical condition if in a residential academic setting.

Please list specific services and accommodations that you would recommend for this student.

The above mentioned disability or disabilities and/or medical condition(s) is/are:

_____ Permanent

_____ Temporary: Anticipated duration of condition _____

Severity is: _____ Mild _____ Moderate _____ Severe

If there are multiple presenting conditions, please explain the duration of each separately.

I certify that all the information on this form is true and correct to the best of my professional knowledge.

Signature of licensed professional _____ Date _____

Title or license type and number if applicable (please print) _____

Please mail or fax this form to:

Office of Accessibility Services

La Roche University

9000 Babcock Blvd., Pittsburgh, PA 15237

Fax: (412)536-1118 Phone: (412)536-1177

For office use only

Form received: _____