

# Verification Form for Acquired Brain Injuries/Disabilities

## Calvin College

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Services to students with disabilities, as part of the Center for Student Success, strives to ensure that qualified students with acquired brain injuries/disabilities are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Calvin College is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the College programs and services. Federal law defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that an acquired brain injury condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to substantially limit one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to acquired brain injuries/disabilities need to have this form filled out by a **certified physician**. The **physician** completing this form must have first hand knowledge of the students' condition, must have experience diagnosing and treating college students and will be an impartial professional who is not related to the student.

### Release of Information

I, \_\_\_\_\_, hereby authorize the exchange and release of the following confidential information to the Center for Student Success and Calvin College for the purpose of determining my eligibility for educational accommodation.

\_\_\_\_\_ Date \_\_\_\_\_ Student's Signature

### Student Information (This section to be completed by the student)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Student ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Certifying Professional

Name \_\_\_\_\_  
Credentials \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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Phone \_\_\_\_\_ Fax \_\_\_\_\_

License/Certification number and state of license \_\_\_\_\_

Signature: \_\_\_\_\_

Date of initial contact with student \_\_\_\_\_ Date of last contact \_\_\_\_\_

**Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_

Date of Diagnosis \_\_\_\_\_

Basis on which diagnosis was made \_\_\_\_\_

Current medications including dosage and side effects \_\_\_\_\_  
\_\_\_\_\_

Long-term treatment plan \_\_\_\_\_  
\_\_\_\_\_

Current compliance with treatment plan: Yes  No  Other \_\_\_\_\_

Prognosis for treatment plan. (Include likelihood of improvement or further deterioration and within what approximate time frame.) \_\_\_\_\_  
\_\_\_\_\_

Planned therapeutic interventions \_\_\_\_\_  
\_\_\_\_\_

Prognosis for therapeutic interventions. (Include likelihood for improvement or further deterioration and within what approximate time frame.) \_\_\_\_\_  
\_\_\_\_\_

Current compliance with therapeutic interventions: Yes  No  Other \_\_\_\_\_

History of hospitalization \_\_\_\_\_  
\_\_\_\_\_

**Implications for Educational Success**

Learning abilities specific to the post-secondary environment that are impaired by the disability (e.g. difficulty with concentration, slow processing speed, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Implications for taking exams and other classroom activities caused by the disability or medications. Please describe and explain why:

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**Suggested accommodations** Each recommended accommodation should include a detailed explanation of its relevance to the disability that is diagnosed. Evaluator also should indicate the level of impaired functioning at which the individual is currently functioning even with the benefits of treatment. Please send a neuropsychological report.

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(Final determination of appropriate accommodations will be determined by our office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.)

**This form should be returned to:**

**Calvin College**  
**Center for Student Success**  
**Attn: Services to Students with Disabilities**  
**1820 Knollcrest Circle SE**  
**Grand Rapids, MI 49546**  
  
**Phone #: (616) 526-6155**  
**Fax #: (616) 526-7066**

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**STUDENT NAME:** \_\_\_\_\_