Verification Form for Mobility Impairments/Disabilities
Calvin College

Services to students with disabilities, as part of the Center for Student Success, strives to ensure that qualified students with mobility impairments/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 a mobility impairment 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 mobility impairment/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)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Student ID#</th>
<th>Date of Birth</th>
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<th>Address</th>
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<tr>
<th>City</th>
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Certifying Professional

Name

Credentials

Address

STUDENT NAME: __________________________________________________________

Page 1
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Calvin College

City __________________________ State ________________ Zip Code __________________
Phone ______________________ Fax ______________________
License/Certification number and state of license ________________________________
Date of initial contact with student ______________ Date of last contact ______________
Signature: ______________________________________________________________________

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.)

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

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.

(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: Disability Services  
1820 Knollcrest Circle SE  
Grand Rapids, MI 49546

Phone #: (616) 526-6155  
Fax #: (616) 526-7066