WILLIAM PATERSON UNIVERSITY
ACCESSIBILITY RESOURCE CENTER • SPEERT HALL 134
300 POMPTON ROAD • WAYNE, NJ 07470-2103
973.720.2853 FAX 973.720.3293 • WWW.WPUNJ.EDU

Student Name: _____

Physician or Disability Evaluator Verification

Accommodations are only available to students identified as having a disability. **A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."** Examples of major life activities are: Major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

Please type answers or write clearly. Forms with illegible handwriting will be returned to student to resubmit.

1. Based on the definition above, does the individual have a disability?_____Yes_____No
   Date of original diagnosis: _____Date of most recent evaluation: _____
   Is the student currently under your care?_____Yes _____No

2. State the student's disability diagnosis, including diagnostic code.

_____

_____

_____

3. Describe the student's functional limitations or behavioral manifestations caused by the condition. Please describe the type, severity, and frequency of symptoms related to this disability. What do you foresee as the impact living in a college residential hall setting?

_____

_____

_____

4. What is the expected duration, stability, or progression of the student's disability?

_____

_____

_____

_____

5. Please describe current treatments, prosthetic devices, and/or medications prescribed.

_____

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_____

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_____

_____

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6. Is this request medically necessary or is it recommended to enhance the comfort and/or convenience of the student? If medically necessary, please explain how the accommodation relates to the impact of the condition.

7. Is there a negative health impact that may be permanent if the request is not met? _____ Yes _____ No

   If Yes, Please Explain: _____

8. Is the request an integral component of a treatment plan for the condition in question? _____ Yes _____ No

9. What is the likely impact on academic performance if the request is not met?

10. What is the likely impact on social development, if any, if the request is not met?

11. What is the likely impact on the student's level of comfort if the request is not met?

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Student Name: _____

THIS SECTION MUST BE COMPLETED FOR FORM TO BE VALID

Physician or disability evaluator INFORMATION (Please Print)

Name:_____

Title:_____ Specialty:_____

Office Address: _____

Phone: _____

License/Certification Number and State of License _____

How long have you treated this patient?_____

Date of most recent office visit? _____

May we contact you if we have questions about this student's accommodation request?____Yes____No

Signature:_____ Date:_____

PLEASE MAIL, FAX or EMAIL COMPLETED FORM
TO: Accessibility Resource
Center William Paterson
University
300 Pompton Road, Wayne, NJ 07470
(973) 720-2853 (p), (973) 720-3293(f)
arc@wpunj.edu