Disability Services
disabilityservices@byuh.edu
808-675-3518

VERIFICATION FORM for MOBILITY and UPPER EXTREMITY IMPAIRMENTS

BYU–Hawaii supports a climate of equal opportunity in its programs, activities, and services according to applicable law, including providing accommodations for students with disabilities. As part of the process for requesting accommodations, a student must provide documentation from a licensed medical practitioner who is the primary treating professional regarding the student's mobility or upper extremity impairments and its impact on the student's major life activity and their need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports, physiological assessments, or secondary school documentation. Any documentation, including this Verification Form, must meet BYUH DS guidelines for mobility impairments.

A summary of the guideline criteria for documenting mobility and upper extremity impairments is listed below (more information related to DS documentation and guidelines for mobility and upper extremity impairments can be found at the following website: https://disability.byuh.edu/

1. Evidence of current mobility or upper extremity impairment
2. Functional impairment affecting an important life skill, including academic functioning
3. History relevant to current mobility or upper extremity impairment, including use of assistive or adaptive technology
4. Summary and recommendations

This form will be reviewed by the Disability Services Coordinator (DSC) who will verify the disability as to the reliability of the request. The DSC will then notify the student if they are eligible for accommodations.

I. Student Information Section: (Please Print Legibly or Type)

BYUH ID #:

Student's Name

First:

Middle:

Sur/Last:

Date of Birth:

Student's Current Address:

Street:

City: State: Zip:

Phone:

Email:

II. Provider Section:

1. Contact with Student

a. Date of initial contact with student:

b. Date of last contact with student:

c. Frequency of appointments with student (e.g., once a week, once a month):

2. Diagnosis

a. What is the student's diagnosis?

b. How long has the student had this impairment?

c. What is the severity of the impairment? Mild Moderate Severe

i. Explain the severity checked above:

d. What is the expected duration of the impairment? Chronic Episodic Short-term

i. Explain the duration checked above:

e. Current Symptoms:

i. Please provide information regarding the student's current symptoms:

ii. Ambulation:

- Is the student able to ambulate? Yes ☐ No ☐
- If yes, how far can the student ambulate without stopping or resting (e.g., one block, one mile, etc.)?

- If no, how does the student negotiate their mobility restrictions? Does the student use a manual wheelchair, motorized wheelchair, scooter, crutches, etc. If so, please explain.

- Can the student negotiate stairs or is an elevator required?

iii. Is there clear evidence that the symptoms associated with the mobility or upper extremity impairment are interfering with or reducing the quality of at least one of the following, including academic functioning? Describe how the impairment interferes with functioning.

School functioning:	
Social functioning:	
Work functioning:	

3. Student's History

a. Please include any historical information relevant to the student's mobility or upper extremity impairment and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial).

b. Assistive or Adaptive Technology:

i. Does the student currently use assistive or adaptive technology to facilitate mobility? If so, please list specifics related to the brand and model number of the assistive or adaptive technology used by the student.

ii. Does the student currently own this adaptive or assistive technology? If so, what brand and model number?

iii. State specific recommendations regarding assistive or adaptive technology for this student based upon the student's functional limitations (e.g., if a screen reader is suggested, please relate the request to the student's mobility impairment.) Please be as specific as possible (e.g., brand name, model number.)

4. Medications

a. Is the student currently taking medication(s) for symptoms associated with the mobility or upper extremity impairment?

Yes ☐ No ☐

b. If yes, please provide information below for each medication the student is currently prescribed:

Medication/Dosage/Frequency:	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication/Dosage/Frequency:	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

5. Functional Limitations and Recommended Accommodations

a. Please list any recommended reasonable accommodations that would mitigate the student's current symptoms associated with the mobility or upper extremity impairment beyond the mobility devices and adaptive or assistive technology listed above. More detailed information regarding reasonable academic accommodations can be found on the DS website at: **https://disability.byuh.edu/**

Symptom:
Recommended Reasonable Accommodation(s):

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Recommended Reasonable Accommodation(s):

III. Provider's Certifying Professional Information:

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed physician, psychiatrist, clinical psychologist, or neuropsychologist). The provider signing this form must be the same person answering the above questions.

***Note**: For ethical reasons, documentation from a family member or relative cannot be accepted, even if they are licensed.

Provider's Name: (International Providers, please fill out as much information as possible about your qualifications)

First:

Middle:

Last:

Credentials:

License Number*:

State of Licensure:

Street Address:

City:

State:

Zip:

Phone #:

Email Address:

Stamp Here (unless provider is from BYUH):

Signature of Provider: Date:

** ***I authorize BYU–Hawaii to receive information from the healthcare provider above. I also authorize my healthcare provider to discuss relevant information as to my condition(s) with the appropriate and qualified BYU–Hawaii personnel on an as-needed basis.***

Signature of Student: Date:

Submitting this Form:
This form may be returned to the student or submitted directly to the Disability Services Office at BYU–Hawaii. Information regarding BYU–Hawaii's Disability Services Office can be found at: https://disability.byuh.edu/. If you have any additional questions, you may contact disabilityservices@byuh.edu or 808-675-3518. Thank you for assisting BYU–Hawaii in this accommodation process.