Provider Verification Form

Name of Student:

UMass Global Campus:

Student ID #:

This form must be completed and signed by a medical or clinical professional. Please return to the Office of Accessible Education at University of Massachusetts Global.

1. *What is the name of the diagnosis/diagnoses?*
2. *How long has the student had this diagnosis/diagnoses?*
3. *What is the severity of this diagnosis/diagnoses?*
4. *Provide duration or recovery period expected.*
5. *Does the diagnosis/diagnoses identified in response to question 1 significantly limit a major life activity of this student? (Yes or No)*
6. *Is there a current treatment plan? (Yes or No). If "yes," please describe the treatment plan.*
7. *List current medication(s), dosage, frequency and adverse side effects, if any.*
8. *If the diagnosis/diagnoses identified in question 1 prevents the student from performing any of the requirements of a course or academic program, please explain.*
9. *Specify recommended accommodation(s) to assist the student in performing these functions and the rational for the recommended accommodations.*

Certifying Medical or Professional

1. Name:
2. Phone Number:
3. License number:
4. Signature: