Medical Provider Verification of Disability

Mayo Clinic College of Medicine and Science
Office of Wellness and Academic Support

Form content not retained in medical record.
For local storage only.

Instructions to Learner: Return this completed report via email to mccms.ds@mayo.edu, fax to 507-422-0926, or mail to Office of Wellness and Academic Support, 200 First Street SW, Rochester, MN 55905.

If you require additional information, email mccms.ds@mayo.edu.

All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

Learner Printed Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*

I am requesting academic support services through the Office of Wellness and Academic Support at the Mayo Clinic College of Medicine and Science. They require current and comprehensive documentation of my condition as one of the criteria used to evaluate my eligibility for disability related accommodations or services. Please respond to the following questions as soon as possible and return to me or send to Mayo Clinic College of Medicine and Science, Office of Wellness and Academic Support.

Learner Signature ▶	Date *(mm-dd-yyyy)*

Provider Information

Printed Name *(First, Middle, Last)*			Title	
License Type	License Number	Phone	Fax	
Organization Name				
Street Address		City	State	ZIP Code

The following must be completed by the health care provider listed above.

1. List the diagnoses (including DSM-V, if applicable) with the principle diagnosis being listed first:

Diagnosis date _____ *(mm-dd-yyyy)* Learner last seen _____ *(mm-dd-yyyy)*

2. Current status of condition(s) (eg, active, progressing, controlled, in remission):

3. How long is this condition(s) likely to persist? Be as specific as possible (eg, lifetime, one academic year, duration of program, one month):

4. Disability Information

Functional Limitations

Indicate the following by checking the appropriate box **without** consideration of mitigating measures (eg, medication). If the condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

Major Life Activities	Negligible	Moderate	Substantial	Don't Know
Self care	☐	☐	☐	☐
Manual tasks	☐	☐	☐	☐
Seeing	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Breathing	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Communicating	☐	☐	☐	☐
Working	☐	☐	☐	☐

5. Symptoms

Describe symptoms, including side effects of treatment and medication, which may affect the Learner's academic performance:

Check the appropriate box to indicate the academic impact of the following.

Activities	Negligible	Moderate	Substantial	Don't Know
Social interactions	☐	☐	☐	☐
Attendance	☐	☐	☐	☐
Keeping appointments	☐	☐	☐	☐
Meeting deadlines	☐	☐	☐	☐
Stress management	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Organization	☐	☐	☐	☐
Cognitive processing	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Processing speed	☐	☐	☐	☐
Other:	☐	☐	☐	☐
Other:	☐	☐	☐	☐

Describe any situations or environmental conditions that might lead to an exacerbation of the condition:

6. Address side effects and limitations of treatment and medications prescribed for this learner that could impair academic performance:

7. What exacerbates the specified disability(ies) of this learner? Be as specific and detailed as possible:

8. List any recommendations for accommodations:

9. Re-evaluation recommended in _____ months, _____ year(s), other (specify) _____

10. Other relevant comments:

Attach any additional report or relevant information.

Health Care Provider Signature

Signature ▶	Date *(mm-dd-yyyy)*