JOHNS HOPKINS
UNIVERSITY

Office of Institutional Equity
Wyman Park Building, Suite 515
3400 N. Charles Street
Baltimore, MD 21218
410-516-8075 / Fax 410-516-5300
www.jhu.edu/oie

Disability Verification Form

(For graduate students and employees)

To be completed by the individual's physician

In order for us to provide disability-related services, we need to establish that this individual has a physical or mental impairment that limits one or more of the major life activities and the impact on essential functions. This form is designed to help us make that determination. Complete documentation guidelines are available at: http://accessibility.jhu.edu/accommodations/

Today's Date: _____ Status (Circle): Graduate Student Employee

Individual's Name: _____ JHU School: _____

DIAGNOSIS

1) Please state the complete diagnosis (**Note: form not for use with ADD/ADHD additional info required**):

_____

_____

2) How did you arrive at your diagnosis? Please check all relevant items below:

Structured or Unstructured interviews	□	Medical tests	□
Interviews with other persons	□	Medical History	□
Behavioral Observations	□	Developmental History	□

3) Please briefly describe as appropriate the history of presenting symptoms and past functioning, duration of the disorder, relevant development, historical and familial data.

_____

_____

_____

HISTORY AND PROGRNOSIS

	Month	Date	Year		Other
Date condition was first diagnosed				[redacted]	
Date individual first seen for the condition					
Date most recently seen for this condition					
Expected duration of condition				Permanent	
How long do you anticipate the impact	3 months	6 months	1 year	More than one year	
Anticipated return to work date				TBD at a later date	
The condition is	stable	improving	worsening	cyclically variable	
The prognosis is	poor	fair	good	excellent	
How often is this individual seen	weekly	monthly	3-6 months	yearly	

4) Is the individual currently taking medication(s) for this issue? YES NO
If yes, what medications is the individual currently taking? For each medication, describe the side effects and any impact on performance. Do limitations/symptoms persist even with medications?

Medication and Dosage	Side Effects	Academic/Work Impact	Persistence of Symptoms

5) Which specific symptoms currently manifesting themselves might affect the individual's ability to do essential functions?

_____

_____

_____

6) Please check which areas listed below the individual is functionally limited in because of the medical diagnosis and/or the medication. Please indicate the level of limitation.

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	2	3	4	5	**Major Life Activities**		1	2	3	4	5	**Learning / Time Management**
					Caring for Oneself							Memory
					Talking							Concentrating
					Hearing							Listening
					Breathing							Organization
					Seeing							Managing distractions
					Walking							Timely submission of assignments
					Standing							Attending class regularly
					Lifting/Carrying							Making and keeping appointments
					Sitting							Managing stress
					Performing Manual tasks							Reading
					Eating							Writing
					Working							Spelling
					Interacting with others							Quantitative reasoning (math)
					Sleeping							Processing Speed

7) Does the impairment substantially limit the operation of a major bodily function? NO YES
If yes, please describe what bodily functions are affected.

_____

_____

_____

_____

8) Please list any specific accommodations or services to address the functional limitations identified above

_____

_____

_____

_____

9) Have there been any changes in the individual's condition in the past 12 months? NO YES
Please explain.

_____

_____

10) Do you anticipate any changes in the individual's condition/medication in the next 12 months?

NO YES

Please explain.

_____

_____

11) Is the individual working with another physician or specialist to treat the condition(s)?

NO YES
Please explain.

_____

_____

12) Is there anything else you think we should know about the individual's medical condition?

_____

_____

_____

_____

Note: The diagnosing professional must have expertise in the differential diagnosis of the documented disorder or condition, follow established best-practices in the field, and not be related to the patient.

_____

PLEASE TYPE OR PRINT CLEARLY

Name/Title _____

Signature_____ Date: _____

License/Certification #_____ State _____

Address _____

City, State, Zip Code_____

Phone _____ Fax _____

Please return form with a letter describing in full detail more information about the medical issue to JHU as quickly as possible.

For Employees: Please return this form and the letter to: Director, ADA Compliance, Office of Institutional Equity, Johns Hopkins University, Wyman Park Building, Suite 515, 3400 N. Charles Street, Baltimore, MD 21218. Phone: (410) 516-8075 . Fax: (410) 516-5300 Email: oiedisability@jhu.edu

For Graduate Students: Documentation must be returned to school Coordinator: http://accessibility.jhu.edu/accommodations/student-accommodations/

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