Form to be completed and signed by Physical/Medical/Mental Health Professional

Provider to submit form via fax or email to SAS@Brown.edu

Student Accessibility Services (SAS)

20 Benevolent Street, Mail Box P, Providence, RI 02912 [P] 401.863.9588 [F] 401.863.1444 http://brown.edu/seas

Verification of a Physical, Medical or Psychological Condition *(Including Temporary)**

INFORMATION MUST BE TYPED OR PROVIDED LEGIBLY

Full Name of Student:____ Student's DOB:__________________

MM/DD/YYYY

Diagnosis: ____

____

Date condition was first diagnosed: ____

Evaluation method(s) used: ____

Date last seen by your office for this condition: ____

Is this treatment ongoing? **YES** ______ **NO** ______ **OTHER**: ______________________________________

The Prognosis is: **PERMANENT/CHRONIC** ________ **TEMPORARY** ________ **UNKNOWN** __________

Estimate Duration for Temporary or Unknown prognoses: ____

Date scheduled for a re-evaluation: ______________________________

MM/DD/YYYY

Condition is currently: **STABLE** ______ **PRONE TO EXACERBATION** ______ **EPISODIC** ______ **IN REMISSION** ______

Severity of symptoms: **MILD** ________ **MODERATE** __________ **SEVERE** ________

Describe the current impact of the condition and any resulting functional limitations. Please refer to the *Documentation Guidelines* for information that should be included in this section. You may attach additional pages if needed.

Continued description of current impact of the condition and any resulting functional limitations.

Full name and Title of verifying professional: ______________________________

Credentials/Specialization of verifying professional: ______________________________

Name of Practice and Location: ______________________________

Office Phone Number: ______________ Office Website: ______________

______________________________ ______________

Signature of Verifying Professional ***Date***

ADDITIONAL INFORMATION AND REGULAR/ANNUAL UPDATES MAY BE REQUIRED. A LETTER OR REPORT FROM PROVIDER MAY BE ATTACHED. MEDICAL PROVIDERS CAN SUBMIT THIS FORM AND/OR ADDITIONAL INFORMATION BACK TO OUR OFFICE VIA FAX OR EMAIL.