

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.

Large rounded rectangular area for text input.

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.