To Evaluator: To qualify for support services from the Accessible Education Center at San José State University, an individual must have his/her disability verified by an appropriate licensed professional. Documentation necessary to substantiate the diagnosis must be comprehensive and be based on a comprehensive diagnostic/clinical evaluation.

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

For general questions pertaining to this form, or to obtain clarification about the information requested, please contact a AEC counselor at 924-6000.

Verification is requested for:

(Last, First M.I.)

Diagnosis:

Date of Diagnosis: Duration of Diagnosis:  
(MM/DD/YYYY) (specify dates)

Description of current functional limitations in the academic environment as well as across other settings. Explanation of how the medical condition impedes performance (e.g. reading, writing, walking, speaking, seeing, and abstract reasoning).
Medication(s) prescribed: ____________________________________________________________

Quantity or dosage: ______________________________________________________________

Anticipated side effects that impact the individual in an academic setting.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Relevant information regarding current treatment plan OR a copy of the treatment plan, if appropriate.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Specific request for accommodations with accompanying rationale. The evaluator must describe the current impact of the diagnosed medical condition on a specific life activity as well as the degree of impact on the individual. A relationship must be established between the requested accommodations and the functional limitations of the individual that are relevant to the academic setting. (e.g., The patient experiences fatigue and a loss of concentration as a result of Chronic Fatigue Syndrome which impacts the patients ability to take tests under standard conditions or focus for an extended period of time; or patient possibly diagnosed with a Herniated Disc experience continual back pain which affects the ability to walk for long distances.)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

__________________________________________________________________________
Certifying Licensed Physician or Primary Health Care Provider qualified in the appropriate specialty area.

Name: ________________________________  (Last, First M.I.)

Medical Facility: ________________________________

Address: ________________________________

City: __________________ State: _____ Zip: ______________

License Number: ________________________________

Signature: ________________________________ Date: ____________