Medical/Mental Health Verification Form

Hope College Disability and Accessibility Resources
PO Box 9000
Holland Mi, 49422-9000 Phone # 616-395-7925
Fax # 616-395-7617

Due to the specific nature of a request for accommod(a)7 0 1 (o)1 (r)n 0 0 Tw c(9)((r)st) 0 0 3c 0 0 Tw 0 2.3 0 0 [76,)5 a

Please note: Disability Services determines appropriate accommodations. For housing related requests, Housing determines placement based on the approved accommodation.

Part 1 (to be completed by s

Part II (to be completed by physician, or mental health provider)

Relevant Diagnosis (disability, acute, or chronic medical or psychological condition):_____

_____

_____

Primary symptoms/behavior addressed in treatment, including date of onset: _____

_____

_____

_____

Brief history of presenting problem: _____

_____

_____

Past treatment: _____

_____

_____

Current treatment, including specific medication(s), and compliance: _____

_____

_____

Description of any current functional limitations: _____

_____

_____

Implications in a residential setting (housing):_____

_____

_____

Implications in the academic environment: _____

_____

_____

Implications for campus accessibility: _____

_____

_____

Licensed Physician/Mental Health Provider (please print)

Name:_____

Credentials:_____

Address:_____

City:_____**State:**_____**Zip:**_____

Phone#:_____ **Fax#:**_____

License # and State of License:_____

_____

Signature of Licensed Physician/Mental Health Professional:_____

_____

Date:_____

Return this completed Medical/Mental Health Verification Form:

Hope College Disability and Accessibility Resources | Fax# 616-395-7617 | dar@hope.edu