BANACOS ACADEMIC CENTER
577 Western Avenue
P.O. Box 1630
Westfield, MA 01086-1630

Westfield STATE UNIVERSITY

Condition Verification Form

Banacos Academic Center's Disability Support Programs

This form is available as a word document online at
https://www.westfield.ma.edu/academics/academic-support/banacos-academic-center/important-forms-and-documents

To be completed by student or Banacos advisor. Student Name: ____ Date of birth: ____________________ Accommodations requested: Please reach out to the student's Banacos advisor with any questions about this form. Banacos advisor: ____ Phone: ____________________________________ Email: ____

Written Verification

In order to determine whether we can reasonably provide the above accommodations, we must have written verification from an appropriate practitioner that a learning, medical, physical or psychological condition exists. **The verification should include the following: a diagnosis, the condition's duration, a description of current functional limitations, a description of current symptoms including severity and frequency, and recommendations for accommodations related to campus life (i.e.; academic, housing, or dining)**. For learning disabilities, a neuropsychological report is needed and, in many cases, an IEP. This form (or a report with comparable information) must be filled out by an appropriately credentialed practitioner. No student, nor student's family member, may fill out this form.

Please fill in the below information. Be descriptive. More information gives us greater flexibility, especially in cases where a diagnosis has not yet been reached, and may provide reasons to support student needs beyond the accommodations requested above.

Clinician information

Clinician name and credentials:	State Licensure Number or Certification (if applicable):
Agency/Institution:	Address: City, State, Zip
Phone:	Fax:

Diagnosis/Condition/Treatment information

For each diagnosis, please provide the following information. Feel free to copy this section for additional diagnoses.

Diagnosis (*DSM-V where applicable*): ____
Date of Diagnosis: ____________________
Length of Time Working with Student: _____________________
Most Recent Evaluation: _________________
Expected duration of the condition (*For example, <6 months, chronic, lifetime*): _____________________
Does this condition substantially limit one or more major life activities? Yes: _______ No: _______
If yes, please list the major life activities here: ____
____

Describe treatment and medication <u>as needed</u> to demonstrate the student's need for potential adjustments to University policies and practices. *For example, describe the effect of adjusting to new medication or of medication that wears off in the middle of the day as it may affect performance in class.*
____
____

Functional Limitations

Please provide a detailed description of how this condition limits the student's life activities listed above in a university setting (housing, dining, academics, internships). Please also include current symptoms, as well as their severity and frequency. *More specific examples are helpful, such as: restricted to walking less than 25 feet; experiences panic attacks in testing situations; explanation of visual acuity; exhibits impulsive behavior; using a computer or monitor for more than 20 minutes creates severe headaches, recovery time from seizures, etc.* ***Please continue on separate page if necessary*.**

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	Severity			
Symptom	Mild	Moderate	Severe	Frequency

Recommendations

Please provide recommendations for support to address functional limitations due to a condition, treatment, and/or medication. We will use the information to determine the reasonableness of accommodations for the student. *For example: 50-100% extended time on exams to address panic from anxiety; assistance with note taking to help with the processing of information (or to compensate for fatigue, distractibility, poor executive functioning skills, etc.); allowance to stand, move, eat, drink, wear sunglasses, etc. in the classroom; assistive technology; adaptive equipment. As before, feel free to copy the below section for additional conditions or functional limitations.*

Functional limitation and its respective condition: ______________________________
Recommendations: ______________________________
____

Functional limitation and its respective condition: ______________________________
Recommendations: ______________________________
____

Functional limitation and its respective condition: ______________________________
Recommendations: ______________________________
____

Please provide any additional information that would be helpful in determining support for the student. Please continue on separate page if necessary.

Please send in any of the below reports or assessments that are available and relevant to the conditions described above. Check the ones that you will send in.

___Audiogram/audiology report
___High School IEP
___Neuropsychological report
___Psychoeducational batteries
___Other ______________________________

Clinician's Signature: ______________________________ **Date**: ____________________