Student Accessibility Services
100 College Drive
Allentown, PA 18104
610-606-4628
Fax: 610-606-4673

Verification Form for Temporary Physical Health Conditions
(Surgery, Injury, Concussion)

Cedar Crest College's Student Accessibility Services office has developed the Verification Form for students with physical health conditions which require temporary accommodations to be obtained from a qualified practitioner (*Medical doctor, Nurse Practitioner, Primary Care Physician*) who has diagnosed a health condition and who has an established, on-going, treatment relationship with the student. **The practitioner must complete this form; it should not be completed by other staff members at the practice or by the student. The practitioner must be licensed to practice in Pennsylvania or the state of the student's permanent residence and may not be a relative of the student.**

1. **To Be Completed by the Student:**

Student Name (Last, First): _____

Date of Birth: _____

Cedar Crest College ID#: _____

Student Email: _____

On Campus Housing or Commuter: _____

Major: _____

Class (Class ID) this Semester being Impacted:

_____

_____

2. **To be Completed by the Practitioner:**

   a. **<u>Health Condition:</u>**

Diagnosis: _____

Diagnosis Code/s: _____

Date of Injury: _____

Date of Initial Visit with Provider: _____

Anticipated Medical Follow-up Date: _____

Any Therapy Required for Treatment:

- Physical Therapy
- Occupational Therapy
- Speech Therapy

*If yes to Therapy, how long: _____

Medications being Used: Yes No

If yes, please list: _____

b. <u>Academics:</u>

Symptoms Impacting Daily Occupations:

_____

_____

Recommended Academic Accommodations to Participate & Engage in Academics:

_____

_____

List Specific Date/s or Time Frame to use Recommended Academic Accommodations

_____

Temporary Accessible Parking Pass Requires: Yes No

If yes, how long: _____

PROVIDER'S CERTIFICATION & PROFESSIONAL INFORMATION

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., Medical doctor, Nurse Practitioner, Psychiatrist, Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor).

☐ **I certify, as the direct treating provider, that I have personally completed this form.**

Provider's Name:

License Number: State of Licensure:

Practice Name:

Street Address:

City: State: Zip Code:

Phone Number:

Provider Signature:

Date Completed:

SUBMITTING THIS FORM

Please mail, fax, or email a Signed Copy of this Form to:

Student Accessibility Services
100 College Drive
Allentown, PA 18014
Fax: 610-606-4673
Rebecca.kile@cedarcrest.edu