Dear Physician or Appropriate Professional,

Your client/patient has requested reasonable accommodations through our Students with Disabilities Services office. Reasonable accommodations are available to students who have a physical or mental impairment that impacts one or more major life activities (i.e., learning, walking, breathing, communication) to the extent that it is necessary to alter standard conditions so that they may complete exams and/or coursework.

To provide your client/patient with reasonable accommodations to assist them in meeting their educational goals, it is necessary to have written documentation verifying the existence of a disability. In addition to a current diagnosis, we require specific information on how it impacts coursework or exams under standard conditions. If you believe that your client/patient has an impairment that causes such a significant impairment in functioning that it constitutes a disability, then please complete the enclosed *Disability Verification Form*.

The information you provide on the *Disability Verification Form* will be used to determine appropriate support services for your client/patient. Please state directly on the attached form the nature of your client/patient's disability and specific limitations in the client/patient's functioning due to this disability.

The criteria used to provide support services are taken directly from the California State University Policy for the Provision of Services to Students with Disabilities. Only those students who have a professionally verified disability that impedes the educational process are eligible to receive support services.

Please keep in mind that attached *Disability Verification Form* is only being used to substantiate the need for reasonable accommodations while enrolled at Gnomon. Your cooperation in assisting us in extending fair and equitable assistance is appreciated. Should you have any questions, I can be reached at 323.466.6663.

Regards,

Student Affairs
Gnomon
studentaffairs@gnomon.edu
323.466.6663

GNOMON

DISABILITY VERIFICATION FORM

SECTION 1: TO BE COMPLETED BY THE STUDENT

Legal First Name: _____ Legal Last Name: _____

Student ID: _____

Address: _____

_____

_____

Email: _____

Name and title of physician or appropriate professional: _____

_____

Address: _____

_____

_____

Phone: _____ Fax: _____

Disability accommodation services that you are requesting:

PERMISSION FOR RELEASE FOR INFORMATION:

For purposes of determining reasonable accommodations, I authorize the release of the medical information and all other information requested on this form to Gnomon students with Disabilities Services. This authorization will remain in effect for one (1) year until _____.

Student Signature: _____ Date: _____

SECTION 2: TO BE COMPLETED BY THE DIAGNOSING PROFESSIONAL

Date(s) of evaluation of your client/patient: _____

Date of most recent contact with your client/patient: _____

What is the nature of your client/patient's impairment?

How long is this impairment expected to last (i.e. number of days, weeks, months, years)?

Does this impairment substantially limit (as compared to the average person) one (1) or more major life activities (e.g. walking, breathing, sleeping or learning) of your client/patient? ☐ Yes ☐ No
If yes, what areas of major life activity are impacted?

What functional limitations does your client/patient experience as a result of his/her impairment?

Based on how this impairment affects your client/patient's ability to function within an academic program or environment, what adjustments to the academic environment would be needed in order for your client/patient to have equal access to academic programs? (Please specify how each adjustment suggested is related to the functional impairment.)

PLEASE COMPLETE THE FOLLOWING SECTIONS THAT APPLY TO YOUR CLIENT/PATIENT'S IMPAIRMENT:

Effects of Prescribed Medications:
What are the effects of any prescribed medications upon your client/patient's normal cognitive and physical capacity?

How long do you anticipate that your client/patient will experience these effects?

Mobility Limitations:
What distance is this individual able to walk without significant fatigue, injury or pain?

How many steps can this person climb? Can he/she walk up a sharp incline?

Perceptual Limitations:

Visual Impairment:	Visual Acuity	Left _____	Right _____
	Visual Field	Left _____	Right _____
Hearing Impairment:	Db Loss	Left _____	Right _____

Does your client/patient require the use of a sign language interpreter: ☐ Yes ☐ No

Neurological Impairments:
Please describe the nature of your client/patient's neurological impairment and its probable impact on the educational process (please attach neurological assessment results):

Psychological or Learning Disabilities (including ADD/ADHD):
DSM-V Diagnosis:
What are your client/patient's current symptoms (include frequency, intensity and duration)?

Describe the deficits in cognitive processing and achievement caused by this impairment:

Describe the assessment/evaluation procedures used to make the diagnosis (please attach copies of assessment results):

Describe any current academic difficulties:

Describe historical information relevant to the diagnosis (including any educational difficulties prior to entering college). For LD and ADHD, include supporting evidence of childhood onset of symptoms (e.g., medical or academic records):

Describe any environmental, social, educational, or language factors that may contribute to psychological, learning or attention problems:

Describe any medical or psychological factors not previously mentioned that might contribute to learning or attention problems:

COMPLETE FOR ALL CLIENTS/PATIENTS:

CERTIFYING STATEMENT OF DISABILITY

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more of the major life activities of such individual" as defined by the Americans with Disabilities Act.

In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Full Name: _____

Signature: _____ Date: _____

License Number (if applicable): _____

PLEASE RETURN TO:

Student Affairs
1015 N. Cahuenga Blvd., Suite 5430i
Los Angeles, CA 90038
- or -
studentaffairs@gnomon.edu