Harvard Division of
Continuing Education

51 Brattle Street
Cambridge, MA 02138-3722

Patient Name:

Provider Verification Form

Your patient has requested academic accommodations for a disabling condition under Section 504 of the Rehabilitation Act and the ADAA (2008). We are seeking your professional input to determine if they qualify and what reasonable accommodations may be necessary and appropriate for accessing the schools' programs and activities. Recommendations for specific accommodations while helpful, do not guarantee the provision of accommodations. Please provide information on the functional impact of their condition within the context of the academic environment.

Student Information:

First Name: Last Name:

Date: Date of Initial Contact:

Date of Condition Onset: Last seen on:

Diagnosis (es):

Please provide a description of the developmental history of the condition including the level of severity (include how the condition was diagnosed, when it was discovered, how it impacted them in previous academic settings):

Accessibility Services Office
Harvard University
Division of Continuing Education

Phone: (617) 998-9640
Fax: (617)998-0694
Email: accessibility@extension.harvard.edu

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Please provide a description of the functional limitations resulting from the condition (Please include any available test results or diagnostic interview findings if available.) What barriers exist in an academic setting? Is it across all settings or specific to certain ones? What symptoms create these barriers?

Please provide a description of assistive devices, therapies and their effectiveness, and medications including any adverse side effects that impact the students' academic work:

Please provide information on recommended accommodations or modifications you believe would be necessary to ensure equal access for the student in an educational environment:

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Patient Name:

Provider Information:

Provider Name:

Provider Signature:

License or Certification Number: State:

Address:

Phone: Email:

Release of Information:

I hereby release my confidential medical information to Harvard University's Division of Continuing Education, Accessibility Services Office for the purpose of obtaining accommodations related to a disability. If information contained in this document is unclear, I hereby give permission to the Accessibility Services Office and my provider named here, permission to discuss my medical situation.

Student Signature: Date:

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