Bucks County Community College

Verification Form

Mobility & Upper Extremity Impairments

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Mobility & Upper Extremity Impairments to obtain current information from a licensed medical practitioner regarding a student's mobility or upper extremity impairment and its impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports, physiological assessments, or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for Mobility & Upper Extremity Impairments. **The person completing this form may not be a relative of the student or hold power of attorney over the student.**

A summary of the guideline criteria for documenting hearing impairments can be found at the following web site: http://www.bucks.edu/student/accessibility/student-info/. A summary of the guideline criteria for documenting Mobility & Upper Extremity Impairments is as follows:

1. Evidence of current mobility or upper extremity impairment
2. Functional impairment affecting an important life skill, including academic functioning
3. History relevant to current mobility or upper extremity impairment, including use of assistive or adaptive technology
4. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: ______________________________

Last First Middle

Student ID: ____________ **Date of Birth:** ____________

Cell Phone: ____________ **Home Phone:** ____________

Bucks Email: ____________ **Home Email:** ____________

Permanent Street Address: ______________________________

City: ____________ **State:** ____________ **Zip:** ____________

Local Street Address: ______________________________

City: ____________ **State:** ____________ **Zip:** ____________

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: ____________

Date of last contact with the student: ____________

Frequency of appointments with student (e.g., once a week, once a month): ____________

B. Diagnosis Information:

1. **What is the student's diagnosis?**

2. When was the student diagnosed with the condition?

__________ Month ______ Year

3. What is the severity of the impairment? ☐ Mild ☐ Moderate ☐ Severe

a. Explain the severity checked above:

4. What is the expected duration of the impairment?

Short-term (<6 months):		Long-term (>6 months-1 year):	
Episodic:		Chronic (>1 year with frequent recurrence):	

c. Explain the duration checked above:

d. Ambulation:

1. Is the student able to ambulate? ☐ **Yes** ☐ **NO**

e. If yes, how far can he or she ambulate without stopping or resting (e.g., one block, one mile, etc.)?

f. If no, how does the student negotiate his or her mobility restrictions? Does the student use a manual wheelchair, motorized wheelchair, scooter, crutches, etc. If so, please explain.

g. Can the student negotiate stairs or is an elevator required?

h. Is there clear evidence that the symptoms associated with the mobility or upper extremity impairment are interfering with or reducing the quality of at least one of the following, including academic functioning?

Environmental Functioning:	
School functioning:	
Social functioning:	
Work functioning:	

C. Student's History:

1. Please include any historical information relevant to the student's mobility or upper extremity impairment and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial)**.**

2. Assistive or Adaptive Technology (AT):

a. Does the student currently use assistive or adaptive technology to facilitate mobility? If so, please list specifics related to the brand and model number of the assistive or adaptive technology used by the student.

b. Does the student currently own this adaptive or assistive technology? If so, what brand and model number?

c. State specific recommendations regarding assistive or adaptive technology for this student based upon the student's functional limitations (e.g., if a screen reader is suggested, please relate the request to the student's mobility impairment.) Please be as specific as possible (e.g., brand name, model number.)

3. **ICD-10-CM Diagnosis Codes:** Please include all pertinent diagnoses or rule-out diagnoses using ICD-10-CM codes.

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D. Medications:

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ Yes ☐ NO
2. If yes, please provide information below for each medication the student is currently prescribed:

Medication • Dosage • Frequency (e.g., Tramadol 100 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

D. Functional Limitations and Recommended Accommodations:

1. Please list the student's current hearing loss symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.
2. **Sample:** A student is unable to grip a pen or pencil requiring use of a computer during class or exams.

Symptom: (Example)
Cannot grip a writing tool
Recommended Reasonable Accommodation(s):
Note-taking assistance / Computer-based exams

Symptom:
Recommended Reasonable Accommodation(s):

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Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information:

(Please type information or print legibly)

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (i.e., licensed medical practitioner). The provider signing this form must be the same person answering the above questions.

Provider's Name: ______________________________
Last First Middle

Credentials: ______________________________

License Number: ______________ **State of Licenser:** ______________

Phone Number: ______________ **Email:** ______________

Practice Street Address: ______________________________
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City: ______________ **State:** ________ **Zip:** ________

May this completed Verification Form be released to the student? ☐ **Yes** ☐ **NO**

Provider Signature: ______________________ **Date:** ______________

Section IV: Submitting this Form

This form should be returned to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. All forms need to be submitted at the Newtown campus. Please see the following methods of submission of this form:

Email: accessibility@bucks.edu

Fax: (215) 968-8033

USPS: Bucks County Community College
Attention: The Accessibility Office
275 Swamp Road
Newtown, Pennsylvania 18940

Physical Drop Off: Newtown Campus
Rollins Center • Student Services Office • Room 001

Information regarding the Accessibility Office (TAO) at Bucks County Community College can be found at http://www.bucks.edu/student/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.

Bucks County Community College does not discriminate in its educational programs, activities or employment practices based on race, color, national origin, sex, sexual orientation, disability, age, religion, ancestry, veteran status, union membership, or any other legally protected category.