Angeles Institute, LLC
WHERE FUTURE NURSES START

VERIFICATION OF DISABILITY

Student Name: _____ DOB: _____

I am requesting academic accommodation(s) through the Student Affairs Department of Angeles Institute. They require current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability related accommodation(s). Please respond to the following questions as soon as possible and return to me or send to Angeles Institute by mail or fax. I authorize the Student Affairs Department at Angeles Institute to contact you if clarification is needed.

_____ _____ _____

Print Name | Signature | Date

Physician/Provider name (print): _____

Title: _____

Phone: _____ Fax: _____

Organization & address: _____

The area below must be completed by the healthcare professional listed above.

1. Diagnosis(es): _____

   _____

   Date of diagnosis(es): _____
2. Current Status of Condition(s) (e.g., Active, Progressing, Controlled, In Remission):
3. Current level of severity (choose one): ☐ Mild ☐ Moderate ☐ Severe
4. How long is this condition(s) likely to persist (be as specific as possible: e.g., lifetime, one academic year; duration of program; one month, six months):
5. Please list procedures/assessments used to diagnose this student's condition.

STUDENT AFFAIRS DEPARTMENT
17100 PIONEER BLVD, SUITE 170
ARTESIA, CA 90701
PHONE: 562-531-4100; FAX: 562-531-4140

6. What are the functional limitations or symptoms of this condition(s)?

7. What exacerbates the specific disability(ies) this student has (please be as specific and detailed as possible)?

8. How does the condition (and/or current treatment or medication(s)) impact the student's ability to learn or meet the demands of the college setting, clinical setting, and/or clinical requirements?

9. Recommendations for reasonable accommodations at the postsecondary level that are supported by the reported signs/symptoms and diagnosis:

   ☐ Extended time for exams/quizzes
   ☐ Preferential seating
   ☐ Other: _____
   ☐ Reduced distraction testing environment
   ☐ Specific clinical site consideration
   ☐ Other: _____

10. Re-evaluation recommended in (check one): ☐ 3 months ☐ 6 months ☐ 1 year
    ☐ Other: _____

11. Other relevant comments: _____

    _____

    _____

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified healthcare provider.

Signature of Treatment Provider _____

License # _____

Date _____

Thank you for your cooperation. You may fax or mail your report to Student Affairs. Please call 562-531-4100 if you require additional information. Please attach any additional reports or relevant information. *All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA)*.

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