



ACCESSIBILITY SERVICES OFFICE
 HARVARD UNIVERSITY DIVISION OF CONTINUING EDUCATION
 Harvard Extension School * Harvard Summer School
 51 Brattle Street, Cambridge, Massachusetts 02138 – 3722
 (Phone) (617) 998-9640 * (Fax) (617) 410-4069 * accessibility@extension.harvard.edu

Chronic Physical/Mental Health Conditions Provider Verification Form

The information supplied on this verification form should reflect the current impact on your patient’s condition. The Health Conditions Provider Verification form should be returned the Accessibility Services Office (ASO) of Harvard University’s Division of Continuing Education. This form is to be completed by the clinician. Please be aware that information which is incomplete or illegible may require additional follow-up from the ASO.

Your client/patient may qualify for reasonable accommodation pursuant to the Americans with Disabilities Act (ADA). We are seeking your professional input in order to determine if your client/patient qualifies as disabled and, if so, what reasonable accommodations may be necessary and appropriate for accessing the School’s programs and activities. In responding below we request information about the nature of the impairment(s), its impact on the student’s major life activities and to what degree.

Date: _____		
Student Name:		DOB: _____
Last: _____	First: _____	M.I.: _____
Date of initial contact with student/patient: _____		
Date of onset of the condition: _____		
Patient was last seen on: _____		

Please list diagnosis(es), symptoms and level of severity compared with most people in the general population	Severity of Dx Frequency of Sx		
Dx 1)	Mild	Moderate	Severe
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Dx 2)	Mild	Moderate	Severe
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Dx 3)	Mild	Moderate	Severe
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant



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Dx 4)	Mild	Moderate	Severe
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Dx 5)	Mild	Moderate	Severe
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant
Sx:	Rarely	Daily	Constant

Please provide information on treatment and side effects of treatment that may be relevant to identifying accommodations:

Please state any recommended accommodations or modifications you believe are *necessary* to ensure equal access for this student in an educational environment:

Please provide information you believe to be relevant that we did not request:



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Provider Information:

Provider Name (print): _____

Provider Signature: _____

License or Certification #: _____ 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 herein permission to discuss my medical situation.

Signed: _____ Date: _____

This release of information is permissible until: (date) _____ or, one year from the date signed.