MEDGAR EVERS COLLEGE
The City University of New York

CUNY

Office of Accessibility and Accommodations Services

1650 Bedford Avenue, Room 1020
Brooklyn, New York 11225
T: (718) 270-5027
F: (718) 270-5003

Verification of Disability Form

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Medgar Evers College. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services. Please take the time to complete this form in its entirety and return it to: Aphifer@mec.cuny.edu or Meak@mec.cuny.edu.

Please note: For hearing disabilities, please attach the most recent audiogram.
For visual disabilities, please attach acuity information.

Student Name: _____

Medical Diagnosis(es): _____

_____

Current Status of Condition(s) (e.g. Active, Progressing, In Remission):

_____

How long is this condition(s) likely to persist (*be as specific as possible: e.g., lifetime, one academic year; one semester; one month*):

_____

What are the student's current functional limitations, e.g., physical – hand function, mobility, hearing, vision limitations; cognitive – learning, memory, concentration problems; interpersonal – difficulty interacting with others; psychological (be specific in all indications)

_____

_____

_____

What exacerbates the specific disability(ies) this student has? (*again, be as specific and detailed as possible*)

_____
_____
_____
_____

Please list any medications related to the condition(s) that the student is currently taking, including dosage and frequency, if pertinent. Please include both the positive as well as any negative effects of the medication:

_____

_____

Please describe the impact this student's condition has on his/her overall ability to learn, or on other cognitive abilities:

_____

_____

_____

Identify any accommodations you believe may be necessary in order for the student to participate in the College's programs, activities and services:

_____

_____

_____

Name of Medical Professional: _____

License #: _____

Telephone: _____

Signature: _____

Date: _____