

**GAU STUDENT AFFAIRS SPECIAL SERVICES
REQUEST FOR ASSESSMENT ACCOMMODATIONS**

Verification Form for Housing, Classroom, Dining Accommodations

Student's Name: _____ **ID** _____

I authorize the Georgetown American University, Student Affairs Special Services to receive information from my healthcare provider (name)_____. I also authorize my provider to discuss my condition(s) with the appropriate and qualified Georgetown American University personnel on an as needed basis.

Student Signature: _____ Date: _____

In order to determine reasonable accommodations for housing and/or classroom and/or the associated dining plan, the Georgetown American University requires current and comprehensive documentation of the student's condition from a licensed clinical professional who is familiar with the student and their diagnose disability and the impact it has on their functioning. *The provider completing this form cannot be a relative of the student.* If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

This form must be completed by a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s).

- 1) Date of Initial Contact with Student: _____
- 2) Date of Last Office Visit with Student: _____
- 3) **Diagnosis:** Please list all relevant diagnoses. If applicable, please list all DSM 5 or ICD Diagnoses (text and code):

- 4) Approximate onset of diagnosis: _____/_____/_____

Severity of symptoms

- mild
- moderate
- severe

Prognosis of disorder:

- good
- fair
- poor

- 5) Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

6) Please list the specific accommodation(s) you recommend to provide the student with equal access to housing, classroom and/or dining:

7) Please explain why the housing, classroom or dining accommodation(s) listed above are necessary to provide this student with equal access to their living/dining experience on our campus based on the impact of their disability. There must be an identifiable relationship between the student's disability and the accommodation being requested.

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via email or postal mail to the GAU Student Affairs office Special Services at the address shown at the end of this document.

All documentation submitted to SASS is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

State of License: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____

Please return this form to:
Georgetown American University
Student Affairs Office
Special Services
81 Croal St. Georgetown,
Guyana
Phone: (592) 226 1375
Email: studentaffairs@gau.edu.gy

Attach Provider Business Card Here

