



Accessibility Services Third-Party Verification Form

4. Please describe how the limitations impact the activities:

a. In the academic environment, if applicable (e.g., difficulty hearing lectures or class discussions, concentration problems while testing or in classroom settings, difficulties interacting in group projects or discussions).

b. In the online learning environment, if different from the information provided above (e.g., using a mouse or keyboard, sensitivity to computer monitor use, understanding written instructions).

5. Have



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Section 2: Expected Duration of Condition

Permanent, continuous: Symptoms and functional limitations are expected to endure throughout their academic tenure with little likelihood of change.

Permanent, episodic: Cycles of wellness interrupted by episodes of sickness or impairment throughout their academic tenure.

Temporary, Functional limitations are temporary, or the severity may change, and should be reassessed by:_____/_____/_____

Provisional: I am still monitoring/assessing the student. Assessment likely to be completed by:_____/_____/_____

Section 3: Current Treatment

1. (Select): Individual/Group Therapy Physical Therapy
 Occupational Therapy Medication Management
 Other: _____

2. Is the student currently taking medications?

- a. Yes No N/A not prescribing physician
 i. If yes, please describe how the medication impacts the student's ability to participate in the educational process or in daily living activities.

3. Does the student utilize any tools or assistive technology to assist with mitigating the symptoms or functional limitations identified? If so, please list.

Accessibility Services
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