

Dear Health Care Provider,

Your patient has notified the College of their chronic health, sensory and/or physical limitation(s). In order to qualify for reasonable accommodations, a student must provide information to Student Disability Services and/or Academic Affairs about the functional limitations presented by their disability in chiropractic education settings. Information, provided by you, in Part II of this form will be discussed during the interactive accommodation request process and assists a student in their request to obtain reasonable accommodations at Palmer College of Chiropractic.

Failure to provide comprehensive information in this document may lead to delays in the delivery of reasonable accommodations or the denial of requested accommodations. Palmer College of Chiropractic cannot accept illegible forms.

Please direct any questions about Palmer's accommodation request process to one of the college officials listed on page 6 of this document. This document comprises two parts:

Part I: Authorization for Disclosure of Health Information - to be completed by the student.

This form will be forwarded to the student's health care provider for completion of Part II.

Part II: Disability Verification and Recommendation - to be completed by the Healthcare

Provider. The evaluating professional completing this form should have training and direct experience in the diagnosis and treatment of adults in the specific area of the condition or disability. Additionally, the evaluator must be familiar with the student's condition and be able to articulate how the student's condition/disability impacts access to educational achievement in the classroom, laboratory, clinic and other chiropractic education settings.

Part I: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____
[Name of Patient] [Date of Birth]

authorize _____ to

complete this Disability Verification and Recommendation Form and speak with the college officials named below for the purpose of coordinating the delivery of reasonable academic accommodations at Palmer College of Chiropractic:

Attn: Academic Affairs; Office of the Dean or Associate Dean Student Disability Specialist

- | | | |
|---|---|---|
| <input type="checkbox"/> <u>Main Campus</u>
<u>1000 Brady Street</u>
<u>Davenport IA, 52803</u> | <input type="checkbox"/> <u>Florida Campus</u>
<u>4777 City Center Parkway</u>
<u>Port Orange, FL 32129</u> | <input type="checkbox"/> <u>West Campus</u>
<u>90 E. Tasman Drive</u>
<u>San Jose, CA 95134</u> |
|---|---|---|

I understand that if the authorized recipient is not a healthcare provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed by the recipient without obtaining any further authorization.

This authorization is granted for the following purpose: the coordination of reasonable academic accommodations necessary to minimize the impact(s) of the students' condition(s) and provide meaningful access in chiropractic educational settings.

PATIENT'S RIGHTS RELATING TO THIS AUTHORIZATION:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form. I understand that I may revoke this Authorization by notifying Palmer College of Chiropractic in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact the Privacy Officer at (563) 884-5701. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This authorization expires 6 months; one year from today's date; upon the following specified event: _____.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes

Name (Signature): _____ Date: _____

Name (Print): _____

Current Address: _____

Part II. Disability Verification and Recommendation - to be completed by the Healthcare Provider.

Patient Name:
Patient's diagnosis (if applicable, include ICD 10 codes):
Presenting problem and background history:
Onset, frequency, intensity and duration of relevant symptoms:
Assessment techniques or diagnostic tests administered to develop the patient's diagnosis:
Dates of assessments:
Description of the specific functional limitations or restrictions the diagnosis presents for the patient, particularly with regard to functioning in a rigorous academic environment.

Evaluator Recommendations

Your recommendations should be based on the student's functional limitations and resulting access barriers. There needs to be a clear rationale to support each recommendation.

What classroom and/or testing modifications will your patient require in order to minimize exacerbations of their condition, medication side-effects and/or the residual functional limitations listed above?

Check all that apply:

- Scribe Supplemental course notes Audio recording of lectures Standing desk Book prop
- Exams printed on colored paper: _____ Computer-based exam Exam reader software
- Adjustable lighting for written exams and quizzes Quiet testing environment
- Modified written and/or practical exam schedule Time and ½ for written exams
- Time and ½ for practical exams Additional time to navigate the campus between classes
- Priority classroom seating: at front, near exit, other: _____ (please circle all that apply)
- Soft or hard seating in class/in testing center (please circle all that apply)
- Modified clinic dress requirements to accommodate prosthetics, lifts or other devices
- Use of a respirator mask in the Anatomy Laboratory Technology-based (dry lab) Anatomy Laboratory equivalent for instruction and testing
- Student is excused from participating as a patient in simulated examination and treatment of the following areas (please select all that apply):
 - Cervical spine Thoracic spine Lumbar spine Sacrum/Pelvis Face/jaw Upper extremity R/L
 - Lower extremity R/L Other: _____

during the following in-class activities (please select all that apply):

- Palpation – static Palpation - motion Prone set-ups Supine set-ups Seated set-ups
- Side-lying set-ups Assessment with instrumentation (Nervoscope, Tytron) of the Cervical spine
- Thoracic spine Lumbar spine Being adjusted by a peer in class Orthopedic and neurologic examination
- Physical examination.

Evaluator Recommendations (continued)

Other classroom, lab or testing accommodations: (please describe)

Provide a clear rationale for the recommended accommodations and/or assistive devices.

Anticipated length of time that modifications or accommodations will be necessary:

I certify that the information on this form is true and correct to the best of my knowledge.

Signature of evaluator

Date

License number: _____ State: _____

Address and contact information for evaluator:

This signed, completed form and any additional supporting documentation including inventories and outcomes assessment forms may emailed or faxed to:

Davenport, Iowa Campus:

- Dr. Kevin Cunningham, Interim Disability Specialist, Phone: (563) 884-5898, Fax: (563) 884-5244, kevin.cunningham@palmer.edu
- Dr. Michelle Drover, Assoc. Dean, Phone: (563) 884-5106, Fax: (563) 884-5532, michelle.drover@palmer.edu
- Dr. Michael Tunning, Assoc. Dean, Phone: (563) 884-5865, Fax: (563) 884-5532, michael.tunning@palmer.edu

Port Orange, Florida Campus:

- Mr. Victor Hidalgo, Disability Specialist, Phone: (386) 763-2780, Fax: (386) 763-2635, victor.hidalgo@palmer.edu
- Dr. William Sherrier, Assoc. Dean, Phone: (386)763-2714, Fax: (386) 763-2757, william.sherrier@palmer.edu
- Dr. Joy Lewis, Assoc. Dean, Phone: (386) 763-2674, Fax: (386), 763-2643, joy.lewis@palmer.edu

San Jose, California Campus:

- Mr. Michael Crump, Disability Specialist, Phone: (408) 944-6122, Fax: (408) 944-6032, michael.crump@palmer.edu
- Dr. Brian Nook, Assoc. Dean, Phone: (408) 944-6055, Fax: (408) 944-6111, brian.nook@palmer.edu
- Dr. Greg Snow, Dean, Phone: (408) 944-6008, Fax: (408) 944-6111, snow_g@palmer.edu

This form was adapted for use at Palmer College of Chiropractic on 11/7/2019 by Alexander D. Margrave, DC from the NBCE Disability Verification and Recommendation Form <https://mynbce.org/wp-content/uploads/2019/10/Verification.pdf>.