Medical/Disability Verification Form for Clerkship-Site Exemptions

The University of Vermont’s (UVM) Student Accessibility Services (SAS) supports students seeking accommodation for disabilities (learning, developmental, psychological, physical or any other chronic medical condition) that impact learning or any other major life activities. SAS strives to ensure that qualified students with disabilities are accommodated in a manner that supports therapeutic treatment(s).

Students with medical conditions who wish to receive an exemption or partial exemption from traveling to distant clinical sites must have this form completed by a qualified health care provider, which may be a certified physician, other diagnosing medical professional, or specialist (such as, but not limited to: an MD, audiologist, neurologist, endocrinologist, psychotherapist). The individual completing this form must have first-hand knowledge of the student’s condition and be an impartial professional who is not related to the student.

Once we receive this completed form, SAS will contact the student and schedule a meeting with a specialist in our office to discuss if the request is approved or if we need further information.

RETURN FORM TO:
DO NOT UPLOAD TO OASIS

Student Accessibility Services
633 Main Street
A170 Living/Learning Building
The University of Vermont
Burlington, VT 05405-0365

Phone: (802) 656-7753
Fax: (802) 656-0739
Email: access@uvm.edu

Student Information (This section to be completed by the student)
Permission to release information to the University of Vermont

Name: (please print) ___________________________ Date: ___________________________
Signed: ________________________________________ UVM Student #: 95 ___________________________
Phone/Email: ________________________________
Please describe your site exemption request: *see “recommendations” section below for clarification
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Specify the medical condition and how it impacts your ability to travel or live away from home.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
*****TO BE COMPLETED BY A CERTIFIED PROFESSIONAL*****

*Note to Provider:

- This student is in a degree program at UVM, that my place them in a clinical site that requires living away from home for 1-7 weeks.
- The student is requesting an accommodation to be exempt or partially exempt from a rotation that requires them to live away.
- As a medical provider we are asking you fill out the form, and specifically to address the extent or frequency of time away that the student can complete without compromising their disability condition.

VERIFICATION OF DISABILITY-RELATED NEED FOR HOUSING ACCOMMODATIONS
To be completed by the current diagnosing professional (please type or print legibly):

Medical Condition/Disability Info:

1. What is/are the diagnosis/es?

   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

2. Severity: Mild Moderate Severe

3. Diagnostic criteria/tests used:

   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

4. What are the dates of the most recent evaluation and last contact with the student?

   ________________________________________________________________________________________

5. What is the expected duration of this condition?

   ________________________________________________________________________________________

6. If relevant, please describe current treatments and/or medications currently prescribed.

   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

7. How does the condition impact the student’s ability to travel or live away from home for a period of time?

   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________

8. Please explain the potential health impact if the recommendations are not provided.

   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________
Recommendations:

☐ Student should not be placed at an away site for any period of time
☐ Student should not be placed at an away rotation for more than _______ weeks at a time*
☐ Student should not be placed at an away site during the following time periods: (list dates)

_____________________

☐ Other/comments:

_______________________________________________________________________________________

_______________________________________________________________________________________

*If the student is able to be placed at an away rotation...will they need a specific housing accommodation (ex. Single room) while living away from home please specify:

_______________________________________________________________________________________

SIGNATURE OF CERTIFYING PROFESSIONAL ________________________________ DATE ____________

Name of Certifying Profession: (please print): ______________________________________________

Credentials: ______________________________________________

License/Certification number and state of licensure: __________________________________________

_______________________________________________________________________________________

Street Address

_______________________________________________________________________________________

Address (City, State, Zip)

_______________________________________________________________________________________

Email Address

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This document may not be released without written permission from the student or by order of a court. It will be destroyed seven years after the student is no longer enrolled at the University.