Note:

Documentation will not be accepted without a Doctor's business card or official office stamp.

KEAN

OFFICE OF ACCESSIBILITY SERVICES

88 Daxue Rd., Ouhai, Wenzhou TEL:(+86) 577-55870153 EMAIL: xiazhenzhen@wku.edu.cn

VERIFICATION OF MEDICAL/PSYCHIATRIC CONDITIONS

The provider who completes this form must be a licensed professional in the State of New Jersey or the student's home state, who has relevant training and experience diagnosing and treating the reported condition, is unrelated to the individual being evaluated and has a history of providing treatment to the student and/or has an ongoing therapeutic relationship.

The student named below has applied for services from the Office of Accessibility Services at Wenzhou-Kean University. In order to determine eligibility and to provide services, we require documentation of the student's disability.

Patient's Name 病人姓名: _____

Patient's Date of Birth 病人生日: _____

Initial Date of Treatment 治疗开始的日期: _____

Last date of Clinical Assessment 上次临床评估的日期: _____

Specific Diagnosis 具体的诊断: _____

Duration of Disability/Condition 症状持续时间: □ Permanent 永久 □Temporary 暂时

If temporary, include expected recovery time 如果是暂时的，请说明预计康复的时间:
□ 1 month 一个月 □ 6 month 六个月 □ 1 year 一年

□ other 其他: please specify 请具体说明 _____

What impact does the illness have on the patient's ability to perform college level academic work? **Be specific.** 请详细说明病人身上的障碍是如何影响其在大学学业/生活上的表现的？

Use space provided or please write on professional letterhead if additional sheets are needed.请在以下页面空白处填写。如需额外纸张，请填写在有专业抬头的信纸上。

In your professional judgment, to what extent will the condition impact the student's academic functioning?根据您的专业判断，此症状会在何种程度上影响该学生的学习/生活表现？

□ Totally Incapacitated 完全丧失能力:

Patient should 病人应该 ____ not register 不注册_____ withdraw from college until 休学直到:

Day 日_____Month 月 _____ Year 年_____

□ Partially Incapacitated 部分丧失能力:

Patient should 病人应该_____reduce his/her course load or 减少其课程量 _____
(other: please specify 如有其他，请说明)
_____

_____

□ Minimally Incapacitated 略微丧失能力:

Patient is expected to function adequately with the following reasonable accommodations 病人应该通过以下合理的辅助安排才能正常活动:

Please list any medications patient is currently taking. (Please include dosage and frequency).请列出病人目前正在服用的药物。（请说明剂量和服药频率）

1.

2.

3.

What potential side effects are associated with the medication(s)?该药物有何副作用？

Date of next assessment 下次临床评估的日期: Day 日_____ Month 月_____ Year 年_____

Proposed Treatment Plan 建议的治疗计划:

(If treatment plan includes study skills workshops, career or personal counseling sessions, etc., student is expected to follow through with these activities.如果治疗计划包括学习技巧辅导、职业或个人心理咨询等，学生应主动参加这些活动。)

Note: Should the student's condition change (for better or worse), the student must provide updated documentation so his/her accommodations will be adjusted accordingly.
注意：如果学生的症状有所改变（更好或更差），该学生必须提供更新的报告文件来获得相应调整后的辅助安排。

Name and contact information for licensed professional 持证医生的姓名和联系方式
(**please use office stamp- or attach business card 请使用公章或附上名片**)

Provider's Signature 医生签名: _____

Date 日期: _____

Unless students provide us with proper documentation, the Wenzhou-Kean University Office of Accessibility Services cannot implement any services for them.除非学生给我们提供准确的文件报告，否则温州肯恩大学共融服务办公室将无法为该生提供任何服务。

We ask that you return this form to 我们邀请您将本表格回递至:

Office of Accessibility Services 共融服务办公室
GEH A219 教学楼 A219
Wenzhou Kean University 温州肯恩大学
88 Daxue Rd., Ouhai, Wenzhou 温州瓯海区大学路 88 号
or 或 Email xiazhenzhen@wku.edu.cn