DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of Teaching and Learning

PHYSICIAN VERIFICATION FORM

(**NOTE**: Provision of incomplete information below may delay application process)

PART I: To be completed by the school's HHIP Designee

Name: _____ DOB: _____ Telephone: _____

School: _____ Grade: _____

Date Parent Received Form: _____ Date Designee Received Form: _____

School Staff Who Received Form: _____

PART II: Treating Physician's Treatment Plan

The treating physician for the diagnosis listed below should complete the following section. We will be contacting the physician with follow-up questions to help us determine the student's eligibility to receive HHIP services.

1. Please indicate the student's diagnosis:

2. How will the physical and/or psychiatric condition you have diagnosed significantly limit the student's ability to receive educational benefits in the regular school setting? In what way(s) would the student's ability to function in the school setting be impacted? Why is the student confined to the home or hospital?

3. Describe your treatment plan for the student. What is the frequency and duration of the treatment?

4. List any medication(s) the student is taking and explain the effects, if any, that the mediation(s) may have on the student's ability to achieve educational benefit in the school setting.

5. **Psychological/Mental Health Cases ONLY**

   Name of treatment program: _____

   Intensive Day Treatment Program?

   Start Date & Start Time: _____ End Date & End Time: _____

   Partial-hospitalization?

   Days: _____ Start Time: _____ End Time: _____

6. **Pregnancy ONLY** – Please provide the Expected Delivery Date: _____

   Is the student on bed rest at this time? **YES** **NO**

   HHIP will provide instruction for 6 weeks (regular) or 8 weeks (cesarean) after delivery. (*Note: Maternity leave and HHIP services begin on the delivery date.*)

7. Recommended date to begin HHIP: _____

   Recommended date student is to return to school: _____

Physician's Certification: I certify that this student is under my care and treatment for the aforementioned illness. My recommendation has been made on the medical needs of the patient.

This certifies that this treatment plan is medically necessary. It MUST be completed by the treating physician or psychiatrist.

Continuation of service beyond 60 calendar days, including emotional conditions requires written re-verification and a medical review. A new Physician Verification Form must be submitted to the HHIP Office prior to the expiration of the 60 calendar days.

_____	_____	_____
(Print) Physician's Name	Physician's Signature	Date

License #: _____

Hospital/Clinic: _____

Phone Number: _____

Email Address: _____

Physician should fax completed forms to 202-654-6020

PRIVACY: In accordance with the Family Educational rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) DCPS ensures that education records, including health records, are not released to third parties outside of emergency circumstances or consent from the parent/guardian. This form will only be accessed by staff either directly involved in deciding about a student's placement or directly involved in administering education services to the student. This form may be shared with school nurses, physicians, and health care providers for treatment purposes only. If there is an emergency threatening the student's safety this information may only be shared with individuals whose knowledge of these records will assist in protecting the student or others from the threat.