KANSAS STATE UNIVERSITY | Student Access Center

DISABILITY VERIFICATION

Students who are requesting services and accommodations are asked to submit documentation in order to establish the presence of a disability and support the reasonableness of requested accommodations. Documentation must clearly demonstrate the current functional limitations in the learning environment. Therefore, the more complete the information you provide the more helpful it will be to the student. This form should be completed by a licensed/certified professional who is in the area in which the diagnosis is made and is not related to the student. THIS FORM SHALL NOT BE COMPLETED BY ANY STUDENT REQUESTING A HOUSING REASONABLE ACCOMMODATION.

Student Name: _____ Date of Birth: _____

Diagnosis: _____

Disability is: ☐ Permanent ☐ Temporary & Expected to last: _____

Level of severity: ☐ Mild ☐ Moderate ☐ Severe

Date(s) of diagnosis: _____

Date of last visit: _____

Provide relevant background information related to student's diagnosis: _____

_____

_____

_____

Functional Impact Assessment: Specify the degree of limitation, if any, that the student currently exhibits within each of the following major areas.

0 = Not Applicable 1 = Mild 2 = Moderate 3 = Severe

	0	1	2	3		0	1	2	3
Care for Oneself					Learning				
Talking					* Reading				
Hearing					* Writing				
Breathing					* Spelling				
Seeing					* Math Reasoning				
Walking/Standing					* Math Calculating				
Lifting/Carrying					* Processing Speed				
Sitting					* Memorizing				
Performing Manual Task					* Concentrating				
Eating					* Listening				
Social Interacting w/others					Working				
Sleeping					Other:				
Thinking					Other:				
Communicating					Other:				

Discuss the functional impact assessment by elaborating on the student's ability to function in a learning environment. Attach objective data to include, but not limited to, aptitude and achievement scores, behavior rating scales, audiogram, visual acuity test and any other pertinent information related to the student's disability. _____

_____

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_____

_____

_____

_____

_____

_____

_____

Is the student prescribed any medication? ☐ **Yes** ☐ **No**

If yes, should we be aware of any side effects? ☐ **Yes** ☐ **No**

List side effects: _____

_____

_____

_____

Name of Professional (please print): _____

Professional Title: _____

Signature of Professional: _____

License #: _____ Date: _____

Address: _____

Phone #: _____ Fax#: _____

Return this form to our office as soon as possible. Please include any verifying documents.

FERPA regulations apply to all documentation provided to this office.