# Disability Verification Form

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.

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| Student’s Information |
| Name: | Date of Birth: |

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| Diagnosis 1 |
| Diagnosis is: |
| Disability is: | [ ]  Permanent | [ ]  Temporary and expected to last:  |
| Level of severity: | [ ]  Mild | [ ]  Moderate | [ ]  Severe |
| Date of diagnosis: | Date of last visit: |

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| Diagnosis 2 |
| Diagnosis is: |
| Disability is: | [ ]  Permanent | [ ]  Temporary and expected to last:  |
| Level of severity: | [ ]  Mild | [ ]  Moderate | [ ]  Severe |
| Date of diagnosis: | Date of last visit: |

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| Diagnosis 3 |
| Diagnosis is: |
| Disability is: | [ ]  Permanent | [ ]  Temporary and expected to last:  |
| Level of severity: | [ ]  Mild | [ ]  Moderate | [ ]  Severe |
| Date of diagnosis: | Date of last visit: |

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| Relevant background information related to student’s diagnosis(es) |
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| Functional Impact AssessmentDiscuss 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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| Medication Side Effect(s)List any side effects of prescribed medication(s) that may impact the student in an academic setting. |
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| Professional’s Information |
| Name of Professional:  |
| Professional Title: |
| License #: | Date: |
| Address: |
| Phone #: | Fax #: |
| Signature of Professional:  |

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.