**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.

<table>
<thead>
<tr>
<th></th>
<th>0 = Not Applicable</th>
<th>1 = Mild</th>
<th>2 = Moderate</th>
<th>3 = Severe</th>
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</thead>
<tbody>
<tr>
<td><strong>Care for Oneself</strong></td>
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<tr>
<td><strong>Talking</strong></td>
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<tr>
<td><strong>Hearing</strong></td>
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<tr>
<td><strong>Breathing</strong></td>
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<td><strong>Seeing</strong></td>
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<tr>
<td><strong>Walking/Standing</strong></td>
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<td><strong>Lifting/Carrying</strong></td>
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<td><strong>Sitting</strong></td>
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<td><strong>Performing Manual Task</strong></td>
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<td><strong>Eating</strong></td>
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<td><strong>Social Interacting w/others</strong></td>
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<td><strong>Sleeping</strong></td>
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<td><strong>Thinking</strong></td>
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<tr>
<td><strong>Communicating</strong></td>
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</tbody>
</table>

* = Assessment

Learning
* = Reading
Writing
* = Spelling
Math Reasoning
* = Math Calculating
Processing Speed
* = Memorizing
Concentrating
* = Listening
Working
Other:
Other:
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.

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.