**NDSU Disability Services**

**Verification of Disability Form**

The individual identified below has or will be requesting accommodations at NDSU once the presence of a disability is confirmed. Please complete the form below to assist NDSU Disability Services staff in determining eligibility status.

If the form is completed without identifying functional limitations its usefulness will be limited, therefore, please be sure to include: **how** this individual is impacted (symptoms) and the **degree** to which s/he is impacted.

*If you have documentation that already answers the questions listed below, you’re invited to submit information on letterhead instead of completing this form.*

**Qualifying professional responds to questions below:**

|  |  |
| --- | --- |
| Patient/Client’s Name:  | Date of Birth:  |
| Diagnosis(es): Diagnostic code(s):  | Date of most recent evaluation/office visit |

1. What **symptoms and/or limitations** pertaining to the diagnosis have been identified for this individual that may impact her/him in the learning environment? (examples may include presence of panic attacks, poor concentration, etc.)

1.

2.

3.

4.

2. In what way(s) is access to the learning environment **substantially** reduced or prevented as a result of these limitations? **Examples**: reduced concentration produces delays when testing, sleep disturbance, memory impairments, reading proficiency, information processing speed, attendance, walking/standing, lifting/carrying, endurance.

3. **State the expected duration, stability, or progression** of the condition. **Important note:** If symptoms are likely to wax and wane, depending on life stressors, variable responses to treatment etc., please be sure to indicate that here. If treatments/medications contribute to adverse side effects, please indicate impact here.

4. Based on the limitation(s) described above, please provide a list of **suggested recommendations** to increase access to the learning environment and campus programming.

**Thank you** for responding to our inquiry regarding the individual named in this form.

**Please sign below to certify that the information provided reflects your professional assessment of the individual’s current level of functioning.**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 date

Print Name & Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE:** Recommendations related to the functional impact of a disability will be carefully considered in an effort to understand the **correlation** between the student’s limitations and the qualifying professional’s suggestions for accommodations/services. The disability services provider will determine whether or not recommendations are reasonable in a post-secondary educational environment and consistent with the Americans with Disabilities Act, the Rehabilitation Act of 1973 (section 504), and relevant legislation that guides this institution.

**Completed forms can be returned to**: NDSU Disability Services, Department 2860, PO Box 6050, Fargo, ND, 58102-6050. Or fax the form to 701.231.8520. Or scan and email to: ndsu.disability.services@ndsu.edu