Disability Verification Form

The Office for Disability Services (ODS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (psychiatrist, psychologist, counselor, therapist, social worker, medical doctor, optometrists, speech-language pathologists etc.) in obtaining the specific information to evaluate eligibility for academic accommodations.

A. The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained, certified, or licensed to diagnosis medical conditions.

B. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. It is recommended that this form be completed by typing the information into the editable PDF version of the form available on our website (www.ati.osu.edu).

C. The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.

D. The information you provide will be kept in the student’s file at ODS, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student’s academic adjustment.

If you have questions regarding this form, please call Silvia Henriss, Coordinator for Disability Services at: 330-287-1253. Thank you for your assistance.
STUDENT INFORMATION

(Please Print Legibly or Type)

First Name: ______________________ Middle: ________________ Last: ___________________________

Date of Birth: ___________________________

Status (check one): ☐ current student ☐ transfer student ☐ prospective student

Local phone: (_______) - ________ - ____________ Cell phone: (_______) - ________ - ________

Address (street, city, state and zip code):

____________________________________________________________________________________

____________________________________________________________________________________

Important: After documentation is reviewed, ODS will contact the student acknowledging receipt of
documentation and the eligibility status.

DIAGNOSTIC INFORMATION

(Please Print Legibly or Type)

1. Date of Diagnosis: _________________________________________________________________

2. Primary Diagnosis: ________________________________________________________________

   Secondary Diagnosis: ________________________________________________________________

3. What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

4. Please state the medication or treatment the student is currently prescribed:

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________

   ________________________________________________________________________________
Major Life Activities Assessment: Please check which of the following major life activities listed below are affected because of the impairment. Indicate severity of limitations.

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<th>Life Activity</th>
<th>Negligible</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Don’t Know</th>
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<td>Concentrating</td>
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<td>Memory</td>
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<td>Eating</td>
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<td>Social Interactions</td>
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<td>Self-Care</td>
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<td>Regular Class Attendance</td>
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<td>Speaking</td>
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<td>Communicating</td>
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<td>Keeping appointments</td>
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<td>Stress Management</td>
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<td>Managing internal distractions</td>
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<td>Sleeping</td>
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<td>Organization</td>
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</table>
6. In addition to the major life activities affected that are indicated above, please describe any activities that may be impacted by the disability or symptoms that may need to be addressed in the college environment:

__________________________________________________________________________________
__________________________________________________________________________________
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7. Please state specific recommendations regarding academic accommodations for this student:

__________________________________________________________________________________
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8. Please add any additional comments that you deem helpful or appropriate:

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HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and completely fill in all other fields using PRINT or TYPE)

Provider Signature: _______________________________  Date: ______________________

Provider Name (Print): _____________________________________________________________

Title: __________________________________________________________________________

License or Certification #: __________________________________________________________

Address:
______________________________________________________________________________
______________________________________________________________________________

Phone Number: (______) - _______ - _____________

FAX Number: (______) - _______ - _____________

Please return completed form to:

Silvia Henriss
Office for Disability Services
Ohio State ATI
1328 Dover Rd.
Wooster, OH 44691-4000

Fax: 330-287-1205

Email: henriss.1@osu.edu