THE OHIO STATE UNIVERSITY

Office for Disability Services

Ohio State ATI/Wooster Campus

128 Skou Hall
1328 Dover Road
Wooster, Ohio
44691

330-287-1258 Phone

cfaes-atiods@osu.edu

Disability Verification Form

The Office for Disability Services (ODS) provides academic accommodations for students with diagnosed disabilities. The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility. **Note:** This form serves as one option (not the only option) for providing disability documentation to ODS. Other examples of documentation include: a physician's letter on letterhead, a diagnostic report, or an IEP/504 plan. To review our documentation guidelines, visit our website (https://ati.osu.edu/currentstudents/studentservices/disability-services).

Please take note of the following as you complete this form:

A. **The person completing this form should be a healthcare professional who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is a part of the student's treatment plan for a previously diagnosed condition.** These professionals are generally trained, certified, or licensed to diagnose and/or treat medical conditions. Examples include: psychiatrist, psychologist, therapist, social worker, medical doctor, optometrist, speech-language pathologist.

B. **Please complete all parts of this form as thoroughly as possible.** Inadequate information, illegible handwriting, or missing fields may delay the eligibility review process by necessitating follow up contact for clarification. An editable PDF version of this form is available on our website (https://ati.osu.edu/currentstudents/studentservices/disability-services).

C. We invite you to attach to this form any other documents or information you think would be relevant in determining the student's academic accommodations.

D. **The information you provide will be kept in the student's file at Disability Services, where it will be held securely and confidentially.** This form may be released to the student at his/her request.

Once completed, please return this form back to the student so that they may upload it with their ODS New Student Application (found on our website). If you have questions regarding this form, please call ODS at 330-287-1258.

Thank you for your assistance.

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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 _____

_____

_____

If current Ohio State student, email address: _____**@buckeyemail.osu.edu**

Other email address _____

DIAGNOSTIC INFORMATION

(Please print legibly or type)

1. Date of Diagnosis: _____

2. Primary Diagnosis: _____

   Other Diagnoses: _____

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

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

_____

_____

_____

Updated 04-2020

5. Please describe how the student's disability symptoms or treatment plan impacts their academics:

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

7. Please add any additional comments that you feel appropriate:

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HEALTHCARE PROVIDER INFORMATION

(Please sign and 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 (_____) -_____- _____