



### **DISABILITY VERIFICATION FORM**

Student Life Disability Services provides equitable academic accommodations and support for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973, Title III of the Americans with Disabilities Act (ADA) of 1990, and the Americans with Disabilities Amendments Act of 2008. The information you provide will *not* become part of the student's educational records but will be kept within the Disability Services Office.

To provide sufficient information regarding the student's disability, please do one of the following:

A. Complete all questions within the Disability Verification form

**or**

B. Provide the following information on professional letterhead:

1. A diagnostic statement identifying the disability
2. Date of diagnosis
3. Name and credentials of the diagnosing professional(s)
  4. Assessments scores (If applicable)
  5. Summary of assessment results
  6. Medication prescribed (if applicable)
7. Recommendation for Academic Support Services
8. Reason(s) for academic support services
9. Attach any reports which provide additional related information

**NOTE:** The professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so such as an M.D., Psychologist, LSW-S, etc.

If you have **questions** regarding this form, please call Student Life at 740-755-7768 or email- [nwk-studentlifedisabilityservices@mail.cotc.edu](mailto:nwk-studentlifedisabilityservices@mail.cotc.edu)

**STUDENT INFORMATION**  
**(Please Print Legibly or Type)**

**Name (Last, First, Middle):**

**ID Number:**

**Phone #:**

**Student E-Mail address:**

**Campus Address (Hall & Room # or Complete Off-Campus Address):**

- 1. What is the diagnosis, date of diagnosis, and last contact with the student?**
  
- 2. Is the student/patient currently under your care?    Yes     No**
  
- 3. What is the severity of the disorder?    Mild     Moderate     Severe**
  
- 4. What is the expected duration of this disability?**
  
- 5. Major Life Activities Assessment (next page):** *Please check which of the following major life activities listed below are affected because of the impairment. Indicate severity of limitations.*

<b>Life Activity</b>	<b>Negligible</b>	<b>Moderate</b>	<b>Substantial</b>	<b>Don't Know</b>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**(Continued on next page)**

- 6. List current medications(s), impact, and adverse side effects.**
  
- 7. What specific symptoms does the student have that might affect the student's academic performance?**
  
  
  
  
  
  
  
  
  
  
- 8. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.**
  
  
  
  
  
  
  
  
  
  
- 9. Please state specific recommendations regarding academic accommodations (e.g., extra time for exams, etc.) for this student, based upon the student's functional limitations. Indicate why the accommodations are necessary.**

**(Continued on next page)**

## HEALTHCARE PROVIDER INFORMATION

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

**Provider Signature:**

**Date:**

**Provider Name (Print):**

**Title:**

**License or Certification #:**

**Business Address:**

**Phone Number:**

**Fax Number:**

**Important:** Please return completed/signed form to the Disability Services Office. The form may be hand delivered, emailed, or faxed to:

**Student Life  
Disability Services  
OSUN/COTC  
Warner Center 226  
Newark, OH 43055  
Phone: (740) 755-7768  
Fax: (740) 364-9646**

**Email:** [nwk-studentlifedisabilityservices@mail.cotc.edu](mailto:nwk-studentlifedisabilityservices@mail.cotc.edu)

**After paperwork is reviewed, SLDS will send a notification to the students email account to start the accommodations process.**