_____ (student name) is a student currently enrolled in _____(program name) and requires a letter from a physician to access academic accommodations. To provide the best possible learning experience for this student, it is imperative that we receive formal confirmation of their diagnosis. All information is kept confidential by our Accessibility Services Department.

VERIFICATION OF DISABILITY FORM

Please print clearly and fully answer the questions below with information about your client's impairment or functional limitations. If you require extra space, please attach a letter with the additional information. Note that the client is responsible for any fees incurred to complete this form.

Client's Full Name: _____

Date of assessment: _____(year/month/day)

Disability Information

Check the box that describes the nature of your client's disability:

☐ **Mobility** ☐ **Hearing** ☐ **Visual** ☐ **Speech** ☐ **Acquired Brain Injury** ☐ **ADD/ADHD**	☐ **Pervasive Developmental Disorder (i.e., autism, neurological)** ☐ **Psychiatric or Psychological** ☐ **Learning -** *students with this type of disability are to submit a Learning Disability Assessment (i.e., psycho-educational assessment)* ☐ **Other, please specify:**

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Describe the impairment or functional limitations of the disability, including the duration and effects of the limitations.

Identification and Signature of Qualified Practitioner

Qualified Practitioner's Full Name: _____

Name of Office (if applicable): _____

Address: _____

Telephone: _____

I certify that the information provided is, to the best of my knowledge, correct and complete.

X _____ _____Signature of Qualified Practitioner