



## Mobility 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. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show functional limitations that impact the individual in the academic setting.

ODS requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary 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 psychologists or members of a medical specialty.

**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 at <http://ods.osu.edu/posts/documents/MD.pdf>.*

**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. *Please do not provide case notes or rating scales without a narrative that explains the results.*

**D. After completing this form, sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to us at the address provided in our letterhead.** The information you provide will *not* become part of the student's educational records, but it 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 the ODS office at 614-292-3307. Thank you for your assistance.

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

Name (Last, First, Middle): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last 4 Digits of SSN: \_\_\_\_\_

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

Local phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Cell phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

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

If OSU Student, OSU E-Mail address: \_\_\_\_\_@OSU.EDU

E-mail address: \_\_\_\_\_

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

1. What is the diagnosis, date of diagnosis, and last contact with the student?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please describe the progression of this condition if applicable.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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3. Describe the symptoms that meet the criteria for the diagnosis. Also, describe how this mobility disability may affect this student both academically and/or physically (functional limitations).

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4. List current medication(s), dosage, frequency, and adverse side effects.

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5. What recommendations do you have regarding accommodations, i.e. extra time for exams, note taker, disability parking, adaptive transportation. Please describe your rationale for the accommodations you have recommended.

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6. Are there other associated disabilities? If so, what are they? Please describe these conditions and any functional limitations.

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## 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 #:** \_\_\_\_\_

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

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**Phone Number:** (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

**FAX Number:** (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

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**Important:** After documentation is reviewed, ODS will send an email notification to the students OSU email account, (e.g. miller.6789@osu.edu), acknowledging receipt of documentation and the eligibility status. Prospective students that do not yet have an OSU email account will be notified via paper letter sent to their home address.