



Disability Verification Form

Student Life Disability Services (SLDS) 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, optometrist, speech-language pathologist, 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 available on our website (slds.osu.edu).***
- C. **The healthcare provider should attach any reports which provide additional related information** (e.g. psychoeducational assessments, neuropsychological test results, Individualized Education Programs [IEPs], etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation in lieu of this form. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.
- 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.

If you have questions regarding this form, please call Disability Services at 614-292-3307. 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 _____

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

Other email address _____

Important: After documentation is reviewed, Disability Services will send an email notification to the student's Ohio State email account, (name.#@osu.edu), acknowledging receipt of documentation and the student's 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:



5. Major Life Activities Assessment: *Please check each of the following major life activities that are impacted by the disability. Indicate severity of limitations.*

Life Activity	Negligible	Moderate	Substantial	Not Sure
Concentrating	<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"/>
Eating	<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"/>
Regular class attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<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"/>
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating	<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"/>
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"/>
Sleeping	<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"/>
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"/>
Performing 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"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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 (_____) - _____ - _____