THE UNIVERSITY OF KANSAS

University Academic Support Centers
Student Access Center

Disability Verification Form

Name of Student: ____ DOB: ______________________

Student Address: ____

Phone: ___________________________________ Email:____

PRIMARY Disability Diagnosis: ____
Please include severity specifier (mild, moderate, severe, partial remission).

SECONDARY Disability Diagnosis: ____
Please include severity specifier (mild, moderate, severe, partial remission).

Please list the symptoms that led to the primary disabling condition:

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Please describe the onset, duration and prognosis of the student's disabling condition including recommendation for re-evaluation:

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Diagnostic Procedures (check all that apply):

- ☐ Clinical Interview
- ☐ Psychological/Psycho-educational Testing
- ☐ Medical
- ☐ Neuropsychological
- ☐ Neurological
- ☐ Audiological
- ☐ Ophthalmological
- ☐ Prior Document Review (e.g., medical, psychiatric or school records)
- ☐ Other: ____

Please attach copies of test data/clinical reports including psychometric summary of scores as appropriate, rating forms and other relevant documents reviewed in this case.

List current medications:	Quantity	Frequency	Side Effects

Please identify functional impact. Specify the degree of limitation, if any, that the student currently exhibits within each of the following major areas. 1 = Mild 2 = Moderate 3 = Severe

	Degree of Impact		
Major Life Activity	1	2	3
Caring for Oneself			
Talking			
Hearing			
Breathing			
Seeing			
Walking/Standing			
Lifting/Carrying			
Sitting			
Performing Manual Task			
Eating			
Social Interacting w/Others			
Sleeping			
Thinking			
Communicating			

	Degree of Impact		
Major Life Activity	1	2	3
Learning			
* *Reading*			
* *Writing*			
* *Spelling*			
* *Math Reasoning*			
* *Math Calculating*			
* *Processing Speed*			
* *Memorizing*			
* *Concentrating*			
* *Listening*			
Working			
Housing & Dining			
Other:			
Other:			

For area(s) marked above as "severe", please elaborate on the impact it may have on the student's ability to function in a university environment.

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What reasonable accommodations would you recommend for the student? Please provide rationale for each recommendation.

1. ____
2. ____
3. ____
4. ____
5. ____

Name of Professional (please print): _______________________________

Signature of Professional: _______________________ Date: ______________

Address: ____

Phone: ______________ Fax: ______________ Email: ______________

License # _______________________________