Verification of Disability Form

Disability Services for Students (DSS) provides academic accommodations for students with diagnosed disabilities. The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility. **Note**: This form serves as one option (not the only option) for providing disability documentation to DSS. Other examples of documentation include: a physician's letter on letterhead, a diagnostic report, or an IEP/504 plan. To review our documentation guidelines, visit our website (https://twu.edu/disability-services/). All documentation provided, including this form once completed, will be kept in the student's confidential file at DSS. Electronic signatures are acceptable.

Student Information

Student full name: ____

Student ID number: ____

Date of birth: ____

TWU email address: ____

I request that the information provided below be provided to DSS in order to determine eligibility for academic accommodations at Texas Woman's University.

____

Student Signature   Date

Disability Information

The information below is to be completed and signed by the Provider.

1. Student's diagnosis(es) (with DSM-V / ICD-10):

   ____

2. Date of onset approximately:

   ____

3. Date of last contact with student:

   ____

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4. How long will the condition likely exist?

____

5. Medication or treatment plan currently prescribed:

____

6. Potential side effects of medication:

____

7. What are the individual's current functional limitations? Related Symptoms?

Life Activity	**No Impact**	**Moderate Impact**	**Severe Impact**	**Don't Know**	**Please describe if moderate or severe impact**
Walking					
Standing					
Sitting					
Performing manual tasks					
Speaking					
Breathing					
Sleeping (or attach most recent sleep study)					
Caring for oneself					
Bodily Functions (immune system, digestive, circulatory, etc.)					
Hearing (or attach recent audiogram)					
Vision (or attach recent eye exam)					
Body control					
Eating					
Concentration					

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Memory					
Reading					
Writing/Keyboarding					
Class Attendance					
Communication – Receptive					
Communication - Expressive					
Sustained Focus					
Other					

8. Are there time, conditions or circumstances which exacerbate the condition?

____

9. Please add any additional comments that you feel appropriate:

____

10. Recommendations for academic and/or residential accommodations:

____

Healthcare Provider Information

Provider signature____

Provider name (print) ____

Title ____

License or certification #____

Address ____

____

Phone number (____) ____-_____ Fax number (____) ____-_____