UNIVERSITY OF RIO GRANDE AND RIO GRANDE COMMUNITY COLLEGE

Accessibility Verification Form for Disability Support Services

The Office of Accessibility provides support services that provide equal access for students with qualifying disabilities. To ensure reasonable accommodations are provided our students, this office requires documentation from their diagnosing or current healthcare provider. Accommodations and services are based on a review of this information, a meeting with the student, and criteria established in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act as Amended. The information provided will not become part of the student's academic record, and confidentiality will be maintained.

Appropriate documentation needs to include, but is not limited to, the following:

1. **Completion by a licensed professional and/or properly credentialed professional** (e.g. medical doctor, psychiatrist, psychologist, clinical counselor, speech-language pathologist, etc.).
   ***The Office of Accessibility does not accept documentation completed by diagnosing/treating professionals related to the student requesting accommodations.*

2. **A thoroughly completed disability verification form.** Where appropriate, summary and data from specific test results should be attached.

   ***If a comprehensive diagnostic report, such as an IEP, 504, etc. is available that provides the requested information, it can be submitted in lieu of the verification form for disability support services.*

3. **A mental health diagnosis should include the diagnosis as based on the DSM V.** Documentation must be **current**. Initial documentation must be based on evaluations performed within 1 year unless the student has remained in clinical contact with his or her evaluator.

   ***All documentation must describe the current impact of the diagnosed impairment(s) and describe medication and treatment modalities.*

4. **The information provided on the disability verification form is maintained by The Office of Accessibility according to the guidelines of the Family Education Rights and Privacy Act (FERPA) of 1974.**

   ***This information may be released to the student upon their written request.*

Please contact Office of Accessibility with questions.
Thank you for your assistance.

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Verification Form for Disability Support Services

STUDENT INFORMATION *(to be completed by student)*

First Name: _____ Last Name: _____

Phone: _____ DOB: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the following individual or organization to release the information included in this document to Office of Accessibility, University of Rio Grande and RIo Grande Community College:

Student Signature: _____ Date: _____

DIAGNOSTIC INFORMATION *(to be completed by medical practitioner/specialist)*

Please specify the specific diagnosis/disability: _____

DSM-5 or ICD Diagnosis & Code: _____

If applicable, please rate the level of severity of the student's diagnosis?
☐ Mild ☐ Moderate ☐ Severe

Duration of condition: ☐ Permanent ☐ Temporary (specify length of time) _____

Date of Diagnosis: _____ Date of last contact with student: _____

How did you arrive at your diagnosis? Please check all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

- ☐ Behavioral Observations
- ☐ Development History
- ☐ Medical History
- ☐ Rating Scales (e.g., CAARS, Brown ADD Scales for AdultsNeuro-Psychological Testing, Date(s) of Testing
- ☐ Psycho-Educational Testing, Date(s) of Testing
- ☐ Structured/unstructured interviews with Person
- ☐ Other (please specify): _____

Describe the particular symptoms of the disability that manifest most significantly for this student:

form continued on next page

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Please describe current treatment protocol, including current medications and possible side effects:

Based on your professional knowledge of the diagnosis, list any suggested accommodations you have for this student in an academic setting:

Please provide any additional information that you think would be useful to know in working with this student:

HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon written request.

Provider Name (PRINT): _____

Provider Signature: _____ Date: _____

Title: _____ License or Certification # _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email address (if applicable): _____

Please have provider's office mail, e-mail or fax this completed form to:

Office of Accessibility
University of Rio Grande/ Rio Grande Community College
Rhodes Student Center, 118
Rio Grande, Ohio
Phone 740-245-7438
Email: accessibility@rio.edu
Fax: 740.245.7341