COPPIN STATE UNIVERSITY

CENTER FOR COUNSELING & ACCESSIBILITY

DISABILITY VERIFICATION FORM

Section 1 – To be completed by student

Name:_____ DOB:_____ CSU ID#_____

Address:_____

City:_____ State:_____ Zip code:_____

Licensed/Certified Professional:_____

Address: _____

Phone#:_____

_____

_____

I authorize the release of the information requested on this Disability Verification Form to Student Accessibility Services, Coppin State University. I understand that this information will remain confidential and will be used only in providing appropriate support necessary for the completion of Coppin State University. This release of information does not permit the disclosure of these records to any other persons or entities without my written consent. I understand that at any time, through written notice I can amend, change, or cancel this agreement with Student Accessibility Services. The revocation of this agreement will have no effect on disclosures previously made. This authorization expires one year from the date, which appears below.

_____ _____

Signature Date

SECTION II-To be completed by Physician or Certified Professional
Please provide the following information in full and attach tests results and/or evaluations.

Specific Diagnosis:
Medical/Physical/Systematic:_____

Blind/Low Vision:_____

Deaf/Hard of Hearing: _____

Head Injury/Traumatic Brain Injury: _____

Psychological (DSM IV Code): _____

Attention Deficit Hyperactivity Disorder (ADHD or ADD):_____

Specific Learning Disability: _____

Severity: ____Moderate ____Severe ____Residual/Remission

Initial Date of Treatment: _____ Date of Last Visit: _____

Duration of the Condition/Disability:

_____Permanent _____ Temporary, what is expected date of recovery _____

If patient has been prescribed medication, please complete the following:

Medication	Quantity	Frequency

What potential side effects are associated with the medication(s) listed above?

Note: Should the student's condition change the student must provide updated documentation so his/her accommodations can be adjusted accordingly.

SECTION III – to be completed by Physician or other Certified Professional

In your professional judgment will the disability/condition have an impact on the student's ability do college work?

Totally incapacitated and should:

___withdraw from university at this time

____not register for courses this semester

Partially incapacitated and has been advised to:

____reduce his/her course load to fewer than 12 credits

____other (please specify) _____

Please check which of the major life activities listed are affected because of the disability:

____Walking ____Speaking ____Seeing ____Hearing ____Concentrating

____Learning ____Memory ____Breathing ____Managing Internal Distractions

____Managing External Distraction ____Performing Manual Task ____None

____Other _____

Briefly describe the current functional limitations on major life activities as a result of the disability and explain how the disability will affect the student in the academic environment:

SECTION IV **– To be completed by Physician or other certifying Professional**

RECOMMENDATIONS:

Please summarize your findings and recommendations for accommodations. All recommendations for accommodations should be directly related to the functional limitations. Clearly state how the accommodations mitigate the impact of the student's disability on specific tasks and activities.

_____

_____

_____

_____

_____

Please Print:

Name: _____

Title: _____

Business Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Phone# _____ **Fax#:** _____

Professional Credentials: _____

Licenses/Certification Number: _____

_____ _____

Signature **Date**

Thank you for your help in providing this information so that we may begin providing services and/or accommodations. Eligibility for services and/or accommodations is heavily based on the documentation provided. Therefore, incomplete information can prevent or delay the provision of services and/or accommodations.