Disability Verification Form

In order to be eligible for disability services the individual requesting (student) must have a documented disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 and Amendment of 2009. A disability is defined as a physical or mental impairment that substantially limits one or more major life activity(s).

This documentation can be viewed in accordance with the Family Educational Rights and Privacy Act (FERPA). A student with a learning disability diagnosis must provide a current and appropriate psychoeducational evaluation, including diagnostic test scores that coincide with the provided evaluation. UTHSC may require additional documentation be provided for any student.

FOR THE TREATING PRACTITIONER AND/OR CLINICIAN: You have been asked by your patient/client to complete this verification form providing documentation of a disability defined by Section 504 of the Rehabilitation Act and The Americans with Disabilities Act of 1990 and Amendment of 2009. Please complete this form in its entirety and attach any additional information needed. Verification forms returned partially complete could result in a delay or denial of accommodations. To accurately complete this form you must:

- Have knowledge of the student's current level of functioning and any potential access barriers this may present in the academic or clinical environment
- Complete the following verification form with current knowledge of the student • Return the completed form to:

Keri Snyder, Accessibility & Accommodations
910 Madison Avenue, Suite 105, Memphis, TN 38163
Phone: 901-448-7745
Email: ksnyde21@uthsc.edu

If you have any questions about this process, please contact Keri Snyder.

Appeals of Accommodation Decisions

Students who wish to appeal a decision regarding an approved accommodation should contact the Director of the Teaching and Learning Center, Tom Laughner, at 901-448-1218 or tlaughner@uthsc.edu. Students will also need to complete and submit an *Appeal of Accommodations Form*, which can be submitted online, by email, or in person to the Teaching and Learning Center at the address above. The appeal will be reviewed by the Appeals Committee. In order to reach a decision, additional documentation may be requested and consultation with appropriate personnel such as faculty, diagnosticians, consultants, and professional experts may be needed.

Student Name: Last:_____First:_____Middle: _____

D.O.B.: _____Date of last office visit: _____

Please provide as much detail as possible so that decisions regarding student's disability-related accommodations are well informed.

Formal Student Diagnosis (including date of diagnosis, DSM-V/ICD-10 codes, including Axis I, II, III, IV and V):

Expected Duration of Student Diagnosis (permanent, temporary, chronic, episodic/reoccurring):

Method used to obtain diagnosis & current symptoms that determine diagnosis:

Impact of symptoms associated with academics and/or clinical rotations:

Severity of condition (please choose): □ Mild □ Moderate □ Severe

Current medications, dosage frequencies and potential adverse side effects of these:

Current therapies and other treatments, frequencies of these and any anticipated hospital stays:

Substantial Impact to Major Life Activities:

Definition: The patient/client's activities are significantly restricted when compared to the average individual in the general population when the conditions, manner or duration under which these activities can be performed are considered.

Please check all functional limitations, including information on how each will impact your patient/client within the academic or clinical environment:

Functional Limitation	Mild	Moderate	Substantial	Comments
Caring for Oneself				
Performing Manual Tasks				
Seeing				
Hearing				
Breathing				
Sleeping				
Eating				
Standing				
Lifting				
Bending				
Walking				
Speaking				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Memory				
Working				
Operation of a major bodily function				
Other:				
Other:				
Other:				

Suggested Reasonable Accommodations:

Each proposed suggestion should include a rationale that is supported by a diagnosis previously documented on this verification form.

Please note: recommended accommodations will be considered, but are not automatically included as part of a student's approved accommodations.

Suggested Accommodation	Rationale	Functional Limitation this may Accommodate

Potential consequences should the student not receive the requested accommodation(s):

Additional Information and/or Comments (background/medical/psychosocial information, etc):

Practitioner Name & Title: _____

Specialty/Qualifications for Determining Diagnosis: _____

State License and/or Certification Number:

___

Practitioner Signature: _____

Date form signed: _____

Address: _____

_____

Phone: _____ Fax: _____