



MEDICAL DISABILITY VERIFICATION FORM

Disability Services may require information and supporting documentation in order to determine eligibility for reasonable accommodations. To assist with this process, please ask your licensed treating physician, medical provider, or clinician to **complete this form in its entirety.**

Section 1: To be completed by the student

| | | |
|---|---------------------------------|----------------------|
| Campus/Location: _____ | Program: _____ | Degree: _____ |
| Term/Start Date: _____ | Student ID Number: _____ | |
| Name of Student/Applicant: _____ | Date: _____ | |
| Home Address _____ | | |
| Phone _____ | Cell _____ | |
| WCU Student Email _____ | | |

Section 2: To be completed by licensed treating medical provider or other certifying professional

| | |
|---|-----------------------------------|
| Statement of Diagnosis (es) or impairment: _____ | |
| Corresponding DSM – V Code: _____ | |
| Check one: Permanent disability _____ | Temporary disability _____ |
| If temporary, length disability is expected to last (number of weeks, days, months): _____ | |
| Date of onset of medical impairment: _____ | Date of Diagnosis: _____ |

Please identify how diagnosis determined: Including additional documentation as required (reports related to tests/evaluations used for diagnosis, treatment plans, etc. - example may be WAIS, Audiologists report):

Please identify if the student is using any measure (e.g. prescriptions, treatment, therapy, etc.) that mitigates the limitations caused by his/her impairment, and, if so, if the mitigating measure(s) eliminates the substantial limitations.

Briefly describe how the disability, current medications, etc., affect functionality in University setting and meeting course requirements:

Recommendation(s) for possible academic adjustments:

Name of certifying official (please print): _____

Title: _____ **License number:** _____

Name of practice: _____

Street Address, City, and Zip code of practice: _____

Telephone number of practice: _____

By signing below, I certify that all information is accurate and complete to be the best of my knowledge.

Signature: _____ **Date:** _____

Please return completed accommodation request form and if required, supporting documentation to the Campus Disability Services Coordinator for consideration.