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.