Disabilities Services
Verification Form for Students with
Physical or Medical Disabilities

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current documentation of the disability. The age of acceptable documentation is dependent upon the condition and the nature of the student's request for accommodations. Disabilities that are sporadic or change over time may require more frequent evaluations. Documentation that reflects the current impact on the student's functioning should be submitted. Present symptoms that meet the criteria for the diagnosis must be noted. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. To standardize our gathering of information, we ask that you complete the following questions, even if the material has already been included in your evaluation. All information will be kept confidential. Please feel free to contact Disabilities Services (DS) at (405) 789-7661 Ext: 3424 with questions.

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The information below is to be completed and signed by the student.

I request and authorize Southwestern Christian University at Bethany, Oklahoma, and Disabilities Services and/or my off-campus provider
(name) ________________________________ to release, fax, mail or discuss with each other information related to my registering with Disabilities Services (DS).

Student Name _____________________________ EID _____________________________

Student Signature ___________________________ Date ___________________________

Email Address: ___________________________ Phone Number: ___________________________

*If the information above is left blank or is incomplete it may delay or prevent DS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.*
The information below is to be completed and signed by the Provider.

1. Diagnosis: Please list all relevant diagnoses.

________________________________________________________________________

a. Approximate onset of diagnosis
   ○ Child-approximate ______________________________
   ○ Adolescent-approximate _________________________
   ○ Adult-approximate ______________________________
   ○

b. Date of your last clinical contact with student: ________/_______/________

2. Evaluation

   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief
      notes that you think might be helpful to us as we determine eligibility for accommodations.
      ○ Medical evaluation (x-ray, lab work, EKG,
      ○ Structured or unstructured interviews with
      ○ Interviews with other persons (i.e. parent, teacher,
      ○ Behavioral
      ○ Neuropsychological testing. Attach
documentation.
      ○ Other (Please ________________________________

   b. Evaluation Results: ____________________________________________

   c. Present symptoms that meet criteria for diagnosis being noted:

   __________________________________________________________________

   d. Current treatment being received by student:

      ○ Medication
         Current medications: _______________________________________________

      ○ Physical / Occupational
         Frequency: _______________________________________________________

      ○ Other (please __________________________________________________
e. Severity of symptoms
   ○
   ○
   ○

f. Prognosis of disorder:
   ○
   ○
   ○

3. Functional Limitations: Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

a. Does this condition significantly **limit one or more of the following major life activities?**

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<thead>
<tr>
<th>Activity</th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<tr>
<td>Communicating</td>
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<td>Concentrating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<tr>
<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Other:</td>
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b. Please check the **functional limitations or behavioral manifestations** for this student:

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<th>Not an Issue</th>
<th>Moderate Issue</th>
<th>Substantial Issue</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<tr>
<td>Meeting Deadlines</td>
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<tr>
<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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<td>Sleep</td>
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<td>Appetite</td>
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<td>Other:</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

d. Special considerations, e.g. medication side effects:

________________________________________________________________________

________________________________________________________________________

e. **COURSE LOAD REDUCTION**: Is the student’s condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

  ○
  ○
  ○ I don’t

If YES please explain:  
________________________________________________________________________

________________________________________________________________________
4. Accommodations

a. Please mark whether student has utilized accommodations in the past.
   ○ Yes- Please
   ○
   ○ Don't

b. (Optional) Recommended educational accommodations:

   

c. (Optional) Please provide any additional information you feel will be useful in determining the
   nature and severity of the student's disability, and any additional recommendations that may
   assist in determining appropriate accommodations and interventions:

   

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information on the next page. This form should be signed and returned via fax or mail to the DS office at the address shown at the end of this document. All documentation submitted to DS is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: ___________________________ Date: ___________________________

Print Name and Title: ___________________________

State of License: ___________________________ License Number: ___________________________

Address ___________________________

Street or P.O. Box ___________________________ City ______ State ______ Zip ______

Phone: ___________________________ Fax: ___________________________

Please return this form to:
Southwestern Christian University at Bethany, Ok
Disabilities Services
7210 NW 39th Expy
Bethany, OK 73008-3637
Phone: (405) 789-7661
Fax: (405) 495-0078
VP (405) 789-7661 Ext: 3424

Attach Provider Business Card Here