



SOUTHWESTERN CHRISTIAN UNIVERSITY AT BETHANY, OKLAHOMA

Disabilities Services • 7210 NW 39th Expy • Bethany, OK 73008-3637
disabilities.services@svcu.edu (405) 789-7661 • FAX (405) 495-0078 • VP (405) 789-7661 Ext: 3424

**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.

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?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				
Other:				

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
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Attach Provider Business Card Here