**Southwestern Christian University**

**Center for Academic and Professional Success (CAPS)/**

**Office of Disabilities Services**

**Verification Form for Students with Physical or Medical Disabilities**

Students seeking support services from Disabilities Services on the basis of a previously diagnosed physical disability or medical condition are requested to submit documentation that verifies their eligibility under Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and the ADA Amendments Act. The documentation should describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activity, or bodily functions. This form is intended to guide the documentation process. Please contact the Office of Disabilities Services at **(405) 789-7661 x2293** with any questions. It is the student’s responsibility to ensure that Disabilities Services receives this form or other appropriate documentation.

**All documentation submitted to the Office of Disabilities Services is considered confidential.**

**Original copies of documentation will not be returned.**



**Student Information:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SCU Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Provider Information:**

I certify, by my signature below, that I am not related to the student. My signature also certifies 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**The information below is to be completed by the Provider.**

1. **Diagnosis: Please list all relevant diagnoses.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. Date diagnosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Date of your last clinical contact with student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **Evaluation**
	1. 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, etc.).
		* Structured or unstructured interview with the student.
		* Interviews with other persons (i.e., parent, teacher, therapist).
		* Behavioral observations.
		* Neuropsychological testing. Attach documentation
		* Other (please specify). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Evaluation Results:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. Present symptoms that meet criteria for diagnosis being noted:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. Current treatment being received by student:
		+ Medication management
		+ Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
		+ Physical / Occupational therapy:

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Approximate age of onset: \_\_\_\_\_\_\_
2. Severity of symptoms

□ Mild □ Moderate □ Severe

g. Prognosis of disorder:

□ Good □ Fair □ Poor

Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Functional Limitations**

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: |  |  |  |  |

1. Please check the current **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:

1. For the purpose of establishing reasonable accommodations, please provide any additional information you feel may be useful for us to know about the student’s disability, if applicable:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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– Thank you –

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