Charleston



University of

**Disability Verification 🟏 Request for Information**

*To be completed by a physician, psychiatrist, social worker or other licensed health provider*

|  |  |
| --- | --- |
| Student Name: |  |

The University of Charleston is committed to providing reasonable accommodations to students with disabilities. The ADA defines a disability as a “physical or mental impairment that substantially limits one or more major life activities.” Please assist us in determining whether the above named student has a disability under the ADA, how the impairment affects the student in their current functioning and as it relates to various demands of higher education (academics, cognitive, social, emotional, physical), and what reasonable accommodation(s) might mitigate the effects of the functional limitations of the impairment.

**Please provide the following information:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Diagnosis (ICD-10 or DSM-5): | | |  | | | |
| Level of Severity: |  | | | | | |
| Date of Diagnosis: |  | | | | | |
| Describe clinical evidence and/or procedure used to diagnose the impairment: | | | | |  | |
| Does the impairment substantially limit one or more major life activities? | | | | Yes | | No |
| If yes, which ones? |  | | | | | |
| Treatments, medications, required medical or assistive devices and/or services, if any: | | | | | | |
|  | | | | | | |
| Presenting symptoms and/or functional limitations in the educational setting: | | | | | | |
|  | | | | | | |
| Potential impact of the impairment and/or side effects: | | | | | | |
|  | | | | | | |
| Restrictions, if any: | |  | | | | |
|  | | | | | | |
|  | | | | | | |
| Possible recommendation, based on functional limitations, for accommodations: | | | | | | |
|  | | | | | | |

Please attach any additional information that you believe to be relevant.

Feel free to contact us for any questions you may have.

By submitting this form, the student has given **Disability & Accessibility Services** permission to contact you if we have any further questions.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Professional’s Signature: | | | | |  | | | | | | | |
| Printed Name & Credentials: | | | | | |  | | | | | | |
| License #: | | |  | | | | | | | | |
| Address: | |  | | | | | | | | | | |
| City: |  | | | | | | State: |  | | | Zip Code: |  |
| Telephone: | | | |  | | | | | Date: |  | |

**Return this information, marked *Confidential,* to:**

University of Charleston

Disability & Accessibility Services

2300 MacCorkle Avenue, SE

Charleston, WV 25304

Phone: 304-347-6983

Fax: 304-357-4972

Email: [asc@ucwv.edu](mailto:asc@ucwv.edu)