Disability Center
University of Missouri

# Disability Verification Form

The Disability Center at the University of Missouri-Columbia is charged with determining students' eligibility for accommodations under the Americans with Disabilities Act (as amended) and Section 504 of the Rehabilitation Act of 1973. Eligibility for accommodations is determined on a case-by-case basis.

The purpose of this form is to assist medical providers documenting a student's relevant disability information for determining eligibility for accommodations. **Note:** This specific form serves as one option for providing disability documentation. Other examples of documentation include a physician's letter on official letterhead, a diagnostic report, or an IEP/504 Plan.

**This form should be:**

- ***Completed by a qualified professional.*** These professionals generally are trained, certified, or licensed to diagnose and/or treat medical conditions, such as psychiatrists, social workers, therapists, medical doctors, and speech-language pathologists. The diagnosing professional should not be related to the student.
- ***Completed as thoroughly as possible.*** Incomplete information, inadequate responses, or illegible handwriting may delay the accommodation review process. The information listed within this form should reflect the most up-to-date information about the student.
- ***Supplemented with any additional documents or information you feel would be relevant in determining the student's eligibility for accommodations.***
- ***Submitted to the Disability Center*** where it will be held securely and confidentially in the student's file. Please note that the information provided in this form may be shared or released to the student upon request.

**To return this form, you may mail, fax, or email it to:**

Disability Center
University of Missouri
S5 Memorial Union
Columbia, MO, 65211
Email: disabilitycenter@missouri.edu
Fax: (573) 884-5002

# Disability Verification Form

_____ _____/_____/_____
Student Name (First and Last) Date of Birth

_____
Student University ID# (if known)

Diagnosis/Diagnoses _____

Date(s) of diagnosis _____

Date of last contact with student _____/_____/_____

What is the expected duration of the disability? (select one)

☐ Permanent ☐ More than 1 year ☐ 1 year or less ☐ 6 months or less

How did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful. If you arrived at your diagnosis using some other form of diagnostic testing, please describe in the space provided below.

☐ Behavioral Observations
☐ Developmental History
☐ Educational History
☐ Interview with Other Individuals
☐ Medical History
☐ Neuro-Psychological Testing, Date(s) of Testing
☐ Psycho-Educational Testing, Date(s) of Testing
☐ Rating Scales (e.g. CAARS, Brown ADD Scales for Adults)
☐ Structured or Unstructured Interviews with Student
☐ Other (please specify below)

Please describe the symptoms associated with this condition that the student is exhibiting.

Please state the medication or treatment the student is currently prescribed and if there are any known side effects the student is experiencing as a result.

What specific accommodations would you recommend for this student? Please provide rationale for each recommendation connecting the student's specific symptomology to the need.

**Note:** *Final determination of accommodations is determined by the Disability Center in accordance with federal mandates and court rulings related to these laws.*

Please add any additional comments that you feel appropriate:

**Qualified Professional Information**

Provider Name (Print)_____

Title _____

License or Certification # _____

Address _____

_____

Phone_____

Fax _____

Provider Signature_____

Date _____/_____/____