Disability Resources
STUDENT AFFAIRS AT WASHINGTON UNIVERSITY

Student Verification of Disability Form

Student Name: _____
Student ID #: _____

This form is to provide disability information and verification for the above-referenced student for the purpose of eligibility for and determination of reasonable accommodations. This form must be completed by a qualified professional that has considerable knowledge of the student's condition and has evaluated for functional/substantial impairment associated with a disability. A **qualified professional** may include a medical doctor, doctor of osteopathic medicine, nurse practitioner, psychologist, psychiatrist, therapist (e.g. LPC, LCSW), or licensed medical treatment provider specialized in diagnostic assessments and treatment associated with the disability (e.g. DPT, MOT), who has direct engagement with the student and can speak to assessed functional limitations. It is generally not appropriate for professionals to treat family members; as such, documentation generated from those related to the student will be considered as supplemental information.

- The form should include the provider's professional evaluation, interpretation, and opinion of the student's diagnosis/es and disability.
- The provider should refrain from restating the student's self-report (e.g. "student reports," "student endorses"); DR requires objective diagnostic impressions.
- Note: Generally, single encounters meant solely for the purpose of obtaining a diagnosis is not, by itself, sufficient to reliably establish that an individual has a non-observable disability or disability-related need for accommodations and may be questioned by DR.
- *For Habif and Mental Health Services: Given the unique relationship of WashU's providers and Disability Resources, Habif and WashU Mental Health Service professionals should focus specifically on the assessed barriers without inclusion of accommodation recommendations. WashU health and mental health care professionals with questions about this expectation should talk with their Director.*

Providers may attach additional supportive documentation, evaluations, or letter to supplement this form. Starred **(*)** questions are required. DR may request additional information/ documentation if this form is incomplete or does not provide the necessary information needed to make a determination.

Providers with questions regarding this form may contact Disability Resources for assistance.

Disability Resources
Washington University in St. Louis
Gregg House, 1st Level
One Brookings Drive
St. Louis, MO 63130-4899
Email: disabilityresources@wustl.edu
Main Phone: 314.935.5970
Fax: 314.612.4526

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Student Verification of Disability Form

Student Name: _____ Student ID: _____ DOB: _____

*Date of initial contact:_____ *Date of most recent formal contact: _____ *Date of initial diagnosis: _____

*Is the student currently under your care? ☐ Y ☐ N *Have you evaluated the student for a disability? ☐ Y ☐ N

*Compliance: ☐ Excellent/Missed 1 – 2x/mo ☐ Fair/Missed 3 - 4x/mo ☐ Poor/Missed >4x/mo ☐ Non-compliant

*Diagnosis/es:

*Diagnostic procedures and/or assessments:

*Relevant history:

*Current symptoms with level of severity (mild, moderate, severe):

*Prognosis:

Provide information regarding medications being prescribed for the above noted diagnoses, and any side-effects which may create further concerns, including medication adjustment.:

*Identify the functional limitations (major life activity/ies substantially restricted) indicated by the evaluation (e.g. breathing, walking, talking, hearing, seeing, sleeping, caring for one's self, performing manual tasks, learning - this list is not exhaustive):

*How do the identified functional limitations/disability impact the student's ability in the University setting (e.g. "Student is substantially limited in the major life activity of learning because of the additional time or effort they must spend to read, write, or learn compared to most people in the general population."):

Additional relevant disability information:

Provider Name: _____ Lic./Cert.No. & Issuing State:_____

Address: _____ Email: _____

City, State: _____ Phone No.: _____

Signature: _____ Date: _____

☐ *Check here if additional pages or documentation is included (e.g., psychoeducation reports, neuropsychological exam, test results, etc.)*