



## Disability Verification Form

Student Life Disability Services (SLDS) provides academic accommodations for students with diagnosed disabilities. The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility. **Note:** This form serves as one option (not the only option) for providing disability documentation to SLDS. Other examples of documentation include: a physician's letter on letterhead, a diagnostic report, or an IEP/504 plan. To review our documentation guidelines, visit our website (<http://slds.osu.edu>).

Please take note of the following as you complete this form:

- A. **The person completing this form should be a healthcare professional who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is a part of the student's treatment plan for a previously diagnosed condition.** These professionals are generally trained, certified, or licensed to diagnose and/or treat medical conditions. Examples include: psychiatrist, psychologist, therapist, social worker, medical doctor, optometrist, speech-language pathologist.
- B. **Please complete all parts of this form as thoroughly as possible.** Inadequate information, illegible handwriting, or missing fields may delay the eligibility review process by necessitating follow up contact for clarification. An editable PDF version of this form is available on our website (<http://slds.osu.edu>).
- C. **We invite you to attach to this form any other documents or information you think would be relevant in determining the student's academic accommodations.**
- D. **The information you provide will be kept in the student's file at Disability Services, where it will be held securely and confidentially.** This form may be released to the student at his/her request.

**Once completed, please return this form back to the student** so that they may upload it with their SLDS New Student Application (found on our website). If you have questions regarding this form, please call SLDS at 614-292-3307.

Thank you for your assistance.



STUDENT INFORMATION

(Please Print Legibly or Type)

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_

Status (check one)

current student  transfer student  prospective student

Local phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Cell phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If current Ohio State student, email address: \_\_\_\_\_@buckeyemail.osu.edu

Other email address \_\_\_\_\_

DIAGNOSTIC INFORMATION

(Please print legibly or type)

1. Date of Diagnosis: \_\_\_\_\_

2. Primary Diagnosis: \_\_\_\_\_

Other Diagnoses: \_\_\_\_\_

3. What is the severity of the disorder?  Mild  Moderate  Severe

4. Please state the medication or treatment the student is currently prescribed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



5. Please describe how the student's disability symptoms or treatment plan impacts their academics:

6. Please state specific recommendations regarding academic accommodations for this student:

7. Please add any additional comments that you feel appropriate:



**HEALTHCARE PROVIDER INFORMATION**

**(Please sign and date below and completely fill in all other fields using PRINT or TYPE)**

**Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Provider Name (print)** \_\_\_\_\_

**Title** \_\_\_\_\_

**License or Certification #** \_\_\_\_\_

**Address** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone Number** (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

**Fax Number** (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_