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Student Disability Services
Disability Verification
Instructions

The purpose of this form is to obtain relevant medical/psychiatric information from a qualified professional about a student who is requesting accommodations to determine whether he/she qualifies as a student with a disability as defined by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act Amendments Act. The information provided herein will also be used by Central Connecticut State University's Student Disability Services to determine what accommodations the student will require to ensure equal access to programs, services and activities available at Central Connecticut State University.

1. The student should complete **Section I: Student Information**.

2. The student, or their parent/legal guardian if under the age of eighteen (18), should complete and sign **Section II: Authorization to Release Health Care Information**. This signature gives the health care provider permission to release the information requested on this form to Central Connecticut State University's Student Disability Services and to speak with a specialist at Student Disability Services.

3. The licensed treating clinical professional or health care provider should complete **Section III: Disability Verification**. The professional/provider must be thoroughly familiar with the student's physical or psychological condition(s) and resulting functional limitations and/or restrictions. Furthermore, the professional/provider may not be related to the student through blood, marriage, or other legal arrangement.

4. This completed form should be submitted to Student Disability Services in any one of the following ways:

Mail/hand delivered:	Student Disability Services Willard Hall, Suite W201 1615 Stanley Street - PO Box 4010 New Britain, CT 06050-4010
Fax:	860.832.1865; Attention: Student Disability Services Director
Email:	Scan and email to DisabilityServices@ccsu.edu

Please contact us directly at 860-832-1952 with any questions.

Thank you for your assistance in this matter.

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Student Disability Services
Disability Verification

Section I: Student Information

Student completes this section.

Student's Name: _____
First *Middle* *Last*

Date of Birth: _____ Student ID: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Phone Number: _____ Email Address: _____

Student status:

☐ Current CCSU Student ☐ Incoming New/Transfer Student

Class standing:

☐ First-Year (0-25 credits) ☐ Sophomore (26-53 credits) ☐ Junior (54-85 credits)
☐ Senior (86+ credits) ☐ Graduate Student

Type of accommodations being requested (check all that apply):

☐ Academic ☐ Housing ☐ Other

Term accommodation is requested to begin:

☐ Fall ☐ Winter ☐ Spring ☐ Summer

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Section II: Authorization to Release Health Care Information

Student or parent/legal guardian completes this section.

I authorize the provider listed below to release information and medical records related to my request to Central Connecticut State University's Student Disability Services for the purpose of determining and obtaining appropriate academic/housing/other accommodations. I understand that Central Connecticut State University's Student Disability Services will review this documentation and may contact me for additional information. Furthermore, I give my consent for a disability specialist from Student Disability Services to contact the professional completing this form for additional information as needed.

Name of Provider: _____

Specialty: _____ Clinic/Facility Name: _____

Address: _____
Street Address

_____
City *State* *Zip Code*

I have read and understand the above information.

_____
Printed Name of Student

_____
Signature of Student or Legal Representative *Date*

_____ _____
Printed Name of Legal Representative Relationship to Student

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Section III: Disability Verification

* Licensed treating, clinical professional or health care provider completes this section.*

Student's Name: _____

To determine eligibility for accommodations associated with a physical or mental impairment, Central Connecticut State University's Student Disability Services requires current, comprehensive documentation of the student's medical/psychological condition from the licensed treating clinical professional or health care provider most familiar with the student's condition and his/her functional limitations. Items 1 through 11 must be completed in full. If the spaces provided are not adequate, please attach additional information using a separate sheet of paper.

1. Please provide complete medical or DSM-5 diagnosis/es.

2. When was this condition(s) diagnosed?

3. When did you last see the student/patient?

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4. Describe the rationale or methodology used to reach the diagnosis/es, as well as the symptoms that meet the criteria for diagnosis/es.

5. How would you describe the **severity** of this/these condition(s)?

6. Mitigating measures aside (i.e., medication or learned behavioral modifications), does the student's disability/health condition **substantially limit any major life activities** (such as concentrating, reading, learning, seeing, hearing, or walking) **and/or significantly affect any major bodily functions** (such as digestion, respiration, bowel/bladder control)? If yes, please describe the impairments, limitations and/or restrictions in detail.

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7. What specific, college-based accommodations would you recommend for this student based on the disability-related impairments you indicated in item 6? Please explain how these accommodations will reduce the effects that the student's impairments may have on academic performance and functioning.

8. List current treatments including therapies (including frequency), medication (including dosage and frequency), and assistive devices.

9. Please include any other information that may help us understand this student's impairments/needs.

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10. For how long do you consider the information you provided in items 1-9 to be valid without reassessment and/or updated information?
    - ❒ The circumstances described in this form are permanent and stationary.
    - ❒ The circumstances described in the form may not be permanent or stationary, but I expect no significant change through_____, _____.
      month *year*

11. If you are related to this student, what is your relationship? _____

All fields below must be completed.

Print Name & Title: _____

Address: _____

_____

Phone Number: _____ Email Address: _____

_____

Signature of Provider *Date*

Provider's Clinic Stamp or License Number/State:

(non -licensed professionals should include a business card)