

# Disability Verification Form

The Office of Accessibility (OA) at The University of Akron provides academic accommodations to students with diagnosed disabilities that reflect a current substantial limitation to learning. To ensure the provision of reasonable and appropriate accommodations for students, this office requires current, comprehensive documentation of the impairment from a current treatment/assessment professional that is legally qualified to make the diagnosis. The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility. This form serves as one option (not the only option) for providing disability documentation to the office. Other examples of documentation include: a physician's letter on letterhead, a diagnostic report, or an IEP/504 plan. The Office of Accessibility has the right to request additional documentation to provide appropriate services.

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. The Office of Accessibility cannot accept disability-related documentation or evaluations from treatment professionals who are related, in any way, to the student requesting services.
- B. Students with coexisting diagnoses of any other disability may need to provide the results of a comprehensive medical, educational or psychological assessment for that disability.
- C. 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.
- D. The information you provide will be kept in the students' file at the Office of Accessibility, where it will be held securely and confidentially. The information provided is maintained in the Office of Accessibility according to the guidelines of the Family Educational Rights and Privacy Act (FERPA). This form may be released to the student at his/her request.

Once completed, please return this form to the student so that they may upload it with their OA [New Student Application](#). If you have questions regarding this form, please contact OA at (330) 972-7928 or [access@uakron.edu](mailto:access@uakron.edu).

## Student Information

(Please print legibly or type)

Name \_\_\_\_\_

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

If current UA student, email address \_\_\_\_\_@uakron.edu

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

## Diagnostic Information

To be completed by Healthcare Professional

(Please print legibly or type)

The information you provide is used to determine whether accommodation(s) are **necessary to ensure equal access** to the university's academic environment.

Please note that accommodations are approved based on **functional limitations related to current symptoms**, not solely on diagnosis or preference. Detailed information describing the **impact of disability in an academic setting** is essential. Documentation that includes only a recommendation without supporting clinical rationale may be insufficient.

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

2. Primary Diagnosis (can include DSM code) \_\_\_\_\_

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

3. What clinical instrument, tests/assessments, diagnostic procedures were used to make this diagnosis (i.e., audiogram, functional capacity evaluations, diagnostic test results, etc.)? Instruments used must be age appropriate and utilize adult norms, unless inapplicable. Please attach relevant test results.



## Treatment/Assessment Professional Provider Information

My signature verifies that I am the treatment/assessment professional and that the contents provided are accurate.

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

Provider Name (print) & Title \_\_\_\_\_

Licensing Credential, Certification #, State \_\_\_\_\_

Agency/Practice \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_