University of South Florida  
Students with Disabilities Services

Verification Form for Students with Physical or Medical Disabilities

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the “Guidelines for Documenting Physical or Medical Disabilities” for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current documentation of the disability. The age of acceptable documentation is dependent upon the condition and nature of the student’s request for accommodations. Disabilities that are sporadic or change over time may require more frequent evaluations. Documentation that reflects the current impact on the student’s functioning should be submitted. Present symptoms that meet the criteria for the diagnosis must be noted. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. To standardize our gathering of information, we ask that you complete the following questions, even if the material has already been included in your evaluation. All information will be kept confidential. Please feel free to contact SDS at (813) 974-4309 with questions.

If documentation is not available or is older than 5 years, please contact SDS and request an in-person meeting. The purpose of the meeting is to discuss possible eligibility for services including history of accommodations and documentation of options.

I request ________________________________ to release, fax, or mail (Provider’s Name) information relating to my condition/diagnosis to the office of Students with Disabilities Services (SDS), University of South Florida.

__________________________________________
Student Name

__________________________________________
Student “U” Number

__________________________________________
Student Signature Date

The information below is to be completed and signed by the Provider
1. Diagnosis: Please list all relevant diagnoses.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

a. Approximate onset of diagnosis
   o Child - approximate age: ________________
   o Adolescent – approximate age: ________________
   o Adult - approximate age: ________________

b. Date of your last clinical contact with student: ________/_______/_______

2. Evaluation
   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.
      o Medical evaluation (x-ray, lab work, EKG, etc.)
      o Structured or unstructured interviews with student.
      o Interviews with other persons (i.e. parent, teacher, therapist).
      o Behavioral observations.
      o Neuropsychological testing. Attach documentation.
      o Psychoeducational testing. Attach documentation.
      o Other (Please specify). ________________________________________________

   b. Evaluation Results
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

   c. Present symptoms that meet criteria for diagnosis being noted:
______________________________________________________________________________
______________________________________________________________________________

   d. Current treatment being received by student:
      o Medication management:
         Current medications: ______________________________________________________
      o Physical/Occupational therapy
         Frequency: _______________________________________________________________
      o Other (please describe): __________________________________________________

   e. Severity of symptoms:
      o Mild
      o Moderate
      o Severe
f. Prognosis of disorder:
   - Good
   - Fair
   - Poor

3. Functional Limitations
   a. Does this condition significantly limit one or more of the following major life activities?

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<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don’t Know</th>
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<td>Manual Tasks</td>
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<td>Other:</td>
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b. Please check the current functional limitations or behavioral manifestations for this student.

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<td>Meeting Deadlines</td>
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<td>Organization</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

d. Special considerations, e.g. medication side effects: _____________________________

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

4. Accommodations
   a. Please mark whether the student has utilized accommodations in the past.
      O Yes – Please describe: _________________________________________________
      O No
      O Don’t know
   b. (Optional) Recommended educational accommodations: _______________________
       ___________________________________________________________________
       ___________________________________________________________________
       ___________________________________________________________________

c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document.

All documentation submitted to SDS is considered confidential.

Provider Information

I certify, by my signature below, that I am not a family member of the student. My signature also certifies that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: ___________________________ Date: ___________________________

Print Name and Title: _____________________________________________________
_______________________________________________________________________
_______________________________________________________________________

State of License: ___________ License Number: _____________________________

Address: ____________________________________________________________________________
_________________________________________________________________________________
(Street or P.O. Box) (City) (State) (ZIP)

Phone: ___________________________ Fax: ________________________________

Please return this form, signed and sealed, to:

The University of South Florida
Students with Disabilities Services
4202 E. Fowler Ave., SVC 1133
Tampa, FL 33620-6923
Phone: 813-974-4309
Fax: 813-974-7337

Attach Provider Business Card Here