

**University of South Florida
Student Accessibility Services**

Verification Form for Students with a Temporary Impairment

Students seeking support services from Student Accessibility Services (SAS) on the basis of a temporary impairment are requested to submit documentation that verifies their eligibility under Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and the ADA Amendments Act. The documentation should describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activity, or bodily functions. This form is intended to guide the documentation process. Please contact SAS at (813) 974-4309 with any questions. It is the student's responsibility to ensure that SAS receives this form or other appropriate documentation.

All documentation submitted to SAS is considered confidential.

Original copies of documentation will not be returned.

| | |
|------------------------------------|---------------------|
| <u>Student Information:</u> | |
| Name: _____ | |
| U Number: _____ | Phone: _____ |
| USF Email: _____ | Date: _____ |

| | |
|---|-----------------------|
| <u>Provider Information:</u> | |
| I certify, by my signature below, that I am not related to 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: _____ |

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Information below is to be completed by the Provider.

1. Current diagnosis, injury, and/or condition:

a. Date diagnosed: _____

b. Date of your last clinical contact with student: _____

c. Approximate duration of diagnosis, injury, and/or condition

_____ 2 weeks or less

_____ 2-4 weeks

_____ 4-8 weeks

_____ 8-12 weeks

_____ Unknown (please explain): _____

2. Functional Limitations

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

| | No Impact | Moderate Impact | Substantial Impact | Don't Know |
|---------------|-----------|-----------------|--------------------|------------|
| Communicating | | | | |
| Concentrating | | | | |
| Hearing | | | | |
| Learning | | | | |
| Manual Tasks | | | | |
| Reading | | | | |
| Seeing | | | | |
| Thinking | | | | |
| Walking | | | | |
| Working | | | | |
| Other: | | | | |

b. Please check the current **functional limitations or behavioral manifestations** for this student:

| | Not an Issue | Moderate Issue | Substantial Issue | Don't Know |
|----------------------|--------------|----------------|-------------------|------------|
| Cognitive Processing | | | | |
| Memory | | | | |
| Processing Speed | | | | |
| Meeting Deadlines | | | | |
| Attending class | | | | |
| Organization | | | | |
| Reasoning | | | | |
| Stress | | | | |
| Sleep | | | | |
| Appetite | | | | |
| Other: | | | | |