



Disability Verification

Disabled Students' Program & Services (DSPS)

Disability Verification

STUDENT INFORMATION (This section must be completed by the student)

Last Name: _____ First Name: _____ Student Number: _____

Former Last Name: _____ Former First Name: _____ Birth Date: _____

I, _____ authorize the release of information from: _____

regarding my disability(ies). All information will be kept confidential and maintained as a part of my DSPS record. I authorize the release of information to include the following records identified below or that the professional designated below complete this form:

Name of Licensed or Certified Professional: _____ Phone: _____

Address: _____

The section below must be completed by licensed or certified professional Please provide the following information in full; attach test scores, reports and other relevant information.

Disability Status

Permanent/Chronic Temporary Less than 45 days Temporary More than 45 days

Side effects of prescribed medication: _____

Disability Description

<input type="checkbox"/> Acquire Brain Injury	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Attention Deficit	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Autism Spectrum		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blind & Low Vision		
<input type="checkbox"/> Hearing (Attach current audiogram)		

Functional Limitations

<input type="checkbox"/> Ambulation	<input type="checkbox"/> Life Planning	<input type="checkbox"/> Visual Acuity
<input type="checkbox"/> Auditory	<input type="checkbox"/> Motor Coordination	<input type="checkbox"/> Visual Processing
<input type="checkbox"/> Basic English/Math Skills	<input type="checkbox"/> Physical Condition	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cognitive Skills	<input type="checkbox"/> Poor Concentration/Memory	
<input type="checkbox"/> Degree of Hearing Loss	<input type="checkbox"/> Poor Dexterity	
<input type="checkbox"/> Recommended services/accommodations: _____		

Licensed Professional

I understand that the information provide by the verifying professional becomes part of the student's records and it may be released to the student upon their request.

Professional Name: _____ Title: _____

Address: _____ Phone Number: _____

Licensed Professional Signature: _____ Date: _____