

Student's Last Name: _____



DISABILITY INFORMATION AND VERIFICATION FORM

Disability and Accessibility Support Services (DAS) in the Student Success Center strives to enable qualified students with disabilities to receive reasonable and appropriate accommodations from the University. To be considered for accommodations a student; 1) must demonstrate a disability covered under the Americans with Disabilities Act (ADA, ADAA) and, 2) the disability must **SUBSTANTIALLY** limit one or more major life activities.

To register with DAS students are required to provide the completed Disability & Verification forms from a qualified and credentialed professional. The professional completing this form must have first-hand knowledge of the student's condition with qualifications and experience diagnosing said condition. **ALL DOCUMENTATION MUST BE CURRENT (within last two years), RELEVANT AND COMPREHENSIVE.**

To facilitate the documentation process, DAS has provided this Disability Information and Verification Form to be completed by the student (Section 1) and a professional (Section 2). PLEASE NOTE THE FOLLOWING:

1. Forms must be filled out completely and accurately. Inadequate information, incomplete answers and/or illegible handwriting may delay the review process.
2. The medical professional should attach any reports which provide information regarding the disability diagnosis (e.g., psychoeducational assessments, neuropsychological test results, etc. updated within the last 2 years).
3. Professionals conducting assessments, rendering diagnosis of a disability, and making recommendations for appropriate/reasonable accommodations must be qualified to do so. The name, title and professional credentials of the evaluator, including information about licensure or certification (e.g., licensed psychologist), as well as the area of specialization, employment and state/province in which the individual practices should be clearly stated in the documentation. ***It is not considered appropriate for professionals to evaluate members of their families*** (must be an impartial evaluator, not in a dual relationship with the student). All reports must be on letterhead, typed, dated, signed and otherwise legible.

DISABILITY INFORMATION AND VERIFICATION FORM

SECTION 1 – To be completed by student

Please complete, sign and **drop off** this page only to:

Laura M. Bagdady

Assistant Director, Student Disability and Accessibility Support Services

4001 W. McNichols

Student Success Center, 3rd Floor of the Library, Rm. 319

Detroit, MI 48221-3038

****The remaining documentation forms (pgs. 3-7) are to be completed by your DIAGNOSING physician/clinician and faxed to: 313-578-0342***

First Name: _____ MI: _____ Last: _____

Date of Birth: _____ UDM ID# _____

Status (check one): _____ current student _____ admitted student

Area of Study: _____ Expected year of graduation: _____

Cell Phone (domestic only): _____

Permanent Home Address: _____

******* I give Laura Bagdady permission to contact my designated physician/clinician to clarify provided information, if needed. _____

Student Signature

UDMercy email: _____

DISABILITY INFORMATION AND VERIFICATION FORM

SECTION 2 pg. 1 DIAGNOSTIC INFORMATION TO BE COMPLETED BY QUALIFIED, CREDENTIALLED PROFESSIONAL

Information provided should be disability-specific.

1. First date of contact with student/patient: _____
2. Last date of contact with student/patient: _____
3. Is the student currently under your care? Yes No
4. Primary Diagnosis and Date of Diagnosis:

5. Secondary Diagnosis and Date of Diagnosis:

6. What is the severity of the condition? Mild Moderate Severe N/A

7. Describe the symptoms that meet the criteria for this diagnosis. **Please attach test results and diagnostic reports (administered within the last 2 years).**

8. Describe the expected duration and/or progress of the disorder. If applicable, please include information about fluctuation of symptoms.

FOR DIAGNOSIS INVOLVING DSM-V

9. What is the DSM-V diagnosis and ICD code(s) for this student?

DISABILITY INFORMATION AND VERIFICATION FORM

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10. In addition to the DSM-V criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes you believe may be helpful in determining which accommodation(s) and/or service(s) are appropriate for the student:

_____ Structured or unstructured interview(s) with the student

_____ Interview with other person

_____ Behavioral observations

_____ Developmental history

_____ Educational history

_____ Medical history

_____ Neuro-psychological testing, including name(s) and date(s) of testing

_____ Standardized or non-standardized rating scales

_____ Other (please specify)

LIFE ACTIVITY	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know	N/A
Seeing						
Hearing						
Speaking						
Sitting						
Standing						
Walking						
Breathing						
Eating						
Sleeping						
Lifting						
Mathematical calculations						
Mathematical reasoning						
Learning						
Thinking (Processing)						
Concentrating						
Managing external distractions						
Managing internal distractions						
Initiating to work (activating)						
Sustaining focus						
Remembering (memorizing)						
Managing stress						
Making/keeping appointments						
Submitting assignments in a timely manner						
Sensory functioning/integrating						
Attending class (regularly and/or on time)						
Understanding directions						
Communicating						
Social interactions						
Writing (manual writing)						
Writing (written expression)						
Reading (decoding)						
Reading (comprehension)						
5/7						

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- Implications for educational success. In addition to the functional limitations listed on pg. 3, please describe any other limitation(s) of the disability for the student as it relates to the educational setting.
- Given the disability, what are your recommended academic accommodations? Include a clear rationale between key components of the diagnosed condition and the accommodation requested (supported by data). (Please do not simply recite student preferences).
- Are there particular situations or environmental conditions that may exacerbate the condition of the student's symptoms?
- Please provide any additional information you think would be useful to know in working with the student to establish reasonable accommodations for their disability.

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Qualified, Credentialed Provider Information

By signing below, you affirm that you are credentialed to make this diagnosis, the information you have provided is accurate and provided in accordance with your best professional judgement. **Additionally, you confirm you are an impartial evaluator not related to nor in a dual relationship with the student.**

Provider Signature: _____

Provider Name (Print): _____

Date: _____

Title: _____

License #: _____

Address: _____

Phone Number: _____

Email: _____