

VERIFICATION OF DISABILITY FORM

***IMPORTANT for Physician or Specialist** – This Verification of Disability form will be used as one of the criteria to determine this student’s eligibility to receive legal accommodation. Please ensure diagnosis accurately represents students disability. **COMPLETE SECTION I & II**

SECTION I

A. Physical Disability: To be completed by a physician.

Primary Diagnosis:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Spinal Cord Injury	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Back Injury	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Amputee
<input type="checkbox"/> Other Disability (<i>Specify</i>): _____		

B. Visual Impairment: To be completed by an ophthalmologist, optometrist or orthoptist or Physician.

I Certify this client to be visually impaired according to the following criteria.

A visual acuity of 6/21 (20/70), or less in the better eye after correction;

A visual field of 20 degrees or less;

Any progressive eye disease with a prognosis of becoming one of the above, in the next two years;

Diagnosis: _____

C. Hearing Impairment. To be completed by a certified audiologist or physician.

Level of hearing loss in the better ear. (Indicate appropriate description[s]).

Uses aided hearing

Would benefit from amplification devices in an educational/vocational setting

Recommend device: _____
(Attach an Audiogram)

D. Neurological Disability. To be completed by a neurologist or neuropsychologist.

Primary Diagnosis:

Traumatic Brain Injury

Other Neurological Disorder (*Specify*): _____

Medication and side effects: _____

E. Learning Disability. To be completed by a registered psychologist or school psychologist.

Psycho-educational assessment

Other Documentation: _____

Primary diagnosis: _____

Identify areas of weakness: _____

F. Psychiatric Disability. To be completed by a clinical psychologist or a psychiatrist.

Primary diagnosis: _____

Medication and side effects: _____

SECTION II

THIS SECTION MUST BE COMPLETED BY ALL CERTIFYING PROFESSIONALS

Print the name of the person being diagnosed: _____

Comment on the **severity, prognosis, and impact** of the medical diagnosis on the applicant's ability to perform tasks involved in achieving educational goals. **Attach all diagnostic documentation.**

Severity: _____

Prognosis: _____

Impact in Educational Setting: _____
(i.e. blurred vision from medication, episodic illness, injury requires stretching every 20 min., etc.) _____

Is the Disability Permanent? Yes No Not Known

Can the student have a copy of this document? Yes No

I certify that the information provided on this form is accurate.

Certifying Professional: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____