MUSKINGUM
UNIVERSITY

Disability Verification Form

Disability Education Office (DEO) provides federally mandated reasonable accommodations to students with diagnosed disabilities. The student listed on the next page has requested accommodations to help alleviate one or more identified symptoms or effects of the student's disability.

The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility.

The information provided below must be completed by someone familiar with the student's disability and the necessity for the requested accommodation. This person may include but is not limited to, a doctor or other medical or mental health professional, service agencies, etc.

Note: This form serves as one option (not the only option) for providing disability documentation to DEO. Disability documentation may include educational or medical records, reports, assessments, Individualized Education Program (IEP), 504 Plan, Evaluation Team Report (ETR), etc. To review additional documentation guidelines, visit our website (http://www.muskingum.edu/deo).

You are invited to attach to this form any other documentation or information you think would be relevant in determining the student's accommodations.

Please return this form to the student or the office indicated below. If we need additional information, we may contact you at a later time.

Thank you for your assistance.

Diagnostic Information:
(Please print legibly or type)

Full Name of Student: _____

Diagnosis: _____

Date of Diagnosis: _____

What is the severity of symptoms? ☐ Mild ☐ Moderate ☐ Severe

Prognosis is: ☐ Permanent/Chronic ☐ Temporary ☐ Unknown

Estimated Duration for Temporary or Unknown prognoses: _____

Please describe the current impact of the condition and any resulting functional limitations with special regards to their housing and/or academics:
Please state specific recommendations regarding accommodations for this student:
Please add any additional comments that you feel appropriate:

Please see next page

Provider Information:
(Please print legibly or type)

Provider Signature: _____ Date: _____

Provider Name (print): _____

Title: _____

License or Certification #: _____ State: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Telephone: _____

Fax or Email: _____