Coppin State University

Center For Counseling & Accessibility

Disability Verification Form

Instructions

Students can use the Disability Verification Form to request academic accommodations at Coppin State University. Students must have the form completed by a qualified, licensed, or certified healthcare provider and submit the completed form through their Coppin Accommodate portal. Submitting this form allows the Center for Counseling & Accessibility to review disability-related functional limitations and determine appropriate accommodations in a timely and confidential manner.

Section 1- To be completed by student

Name: Date of Birth:		
Coppin State University ID#:		
Email Address:		
Address (City, State, Zip code):		
Licensed Professional Name:		
Licensed Professional Phone Number:		
Licensed Professional Address:		

Release of Information Consent

I authorize the release of the information requested on this Disability Verification Form to Student Accessibility Services, Coppin State University. I understand that this information will remain confidential and will be used only in providing appropriate support necessary for the completion of Coppin State University. This release of information does not permit the disclosure of these records to any other persons or entities without my written consent. I understand that at any time, through written notice I can amend, change, or cancel this agreement with Student Accessibility Services. The revocation of this agreement will have no effect on disclosures previously made. This authorization expires one year from the date, which appears below.

Name :		Date:	

Note: Should the student's condition change the student must provide updated documentation so his/her accommodations can be adjusted accordingly.

DSSP-FORM-006-DISABILITY VERIFICATION.DOC / REV012316

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Section 2- To be completed by Physician or Certified Professional

Please provide the following information in full and attached tests results and/or evaluations

Specific Diagnosis:		Blind/Low Vision	
Deaf/Hard of Hearing:		Head Injury/Traumatic Brain Injury:	
Psychological (DSM IV Code):		Attention Deficit Hyperactivity Disorder (ADHD or ADD):	
Specific Learning Disability (Specify whether Moderate, Severe, or Residual/Remission):		Initial Date of Treatment:	
Specific Diagnosis		Date of Last visit	
Specify the duration of the Condition/Disability (Permanent or Temporary? If Temporary, what is expected date of recovery?):			

If patient has been prescribed medication, please complete the following:

Medication	Quantity	Frequency

What potential side effects are associated with the medications listed above?

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Section 3 -to be completed by Physician or other Certified Professional

In your professional judgment will the disability/condition have an impact on the student's ability do college work?

Totally incapacitated and should:

Withdraw from university at this time	
Not register for courses this semester):	
Totally incapacitated and should:	

Reduce his/her course load to fewer than 12 credits:				other (please specify):	
Please check which of the major life activities listed are affected because of the disability:					
Walking:	☐	Speaking:	☐	Seeing:	☐
Hearing:	☐	Concentrating:	☐	Learning:	☐
Memory:	☐	Breathing:	☐	Managing Internal Distractions:	☐
Managing External Distractions:	☐	Performing Manual Task	☐	None	☐
Other:					
Specify the duration of the Condition/Disability (Permanent or Temporary? If Temporary, what is expected date of recovery?):					

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SECTION III Continued- to be completed by Physician or other Certified Professional

Briefly describe the current functional limitations on major life activities as a result of the disability and explain how the disability will affect the student in the academic environment:

SECTION IV – To be completed by Physician or other certifying Professional

RECOMMENDATIONS:

Please summarize your findings and recommendations for accommodations. All recommendations for accommodations should be directly related to the functional limitations. Clearly state how the accommodations mitigate the impact of the student's disability on specific tasks and activities.

SECTION IV CONTINUED – To be completed by Physician or other certifying Professional

Please Print:

Name:

Title:

Business Address

City, State, Zip code:

Phone:

Fax:

Professional Credentials:

Licenses/Certification Number:

Signature:

Date:

Thank you for your help in providing this information so that we may begin providing services and/or accommodations. Eligibility for services and/or accommodations is heavily based on the documentation provided. Therefore, incomplete information can prevent or delay the provision of services and/or accommodations.