Student Disability Services ♦ ♦ Haggar 253
1845 East Northgate Drive ♦ Irving, Texas 75062 ♦ www.udallas.edu/academic-success
Phone (972) 721-5056 ♦ Facsimile (972) 265-5712 ♦ Email ada@udallas.edu

Student Disability Services
Verification Form for Students with Physical Disabilities or Medical Conditions

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the "Guidelines for Documenting Physical Disabilities or Medical Conditions" for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current documentation of the disability. The age of acceptable documentation is dependent upon the condition and the nature of the student's request for accommodations. Disabilities that are sporadic or change over time may require more frequent evaluations. Documentation that reflects the current impact on the student's functioning should be submitted. Present symptoms that meet the criteria for the diagnosis must be noted. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. To standardize our gathering of information, we ask that you complete the following questions, even if the material has already been included in your evaluation. All information will be kept confidential. Please feel free to contact the ADA/Section 504 Coordinator at (972) 721-5056 with questions.

The information below and the release of information on the second page are to be completed and signed by the student.

_____

Student Name UD ID

_____

Student Signature Date

Email Address: _____

Phone Number: _____

If the information above is left blank or is incomplete it may delay or prevent SDS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION TO STUDENT DISABILITY SERVICES

Pursuant to Federal and State law concerning my right to confidentiality and privileged communication, I, _____, hereby authorize:

_____
Person or Organization

_____
Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

To release the following information:

_____ Information Requested on this Verification Form

_____ Diagnosis

_____ Psych-Educational/Neuropsychological Evaluations

_____ Psychological Evaluation

_____ History of previously used accommodations

_____ Other: _____

Purpose of disclosure:

Documentation needed to request academic, dietary, and/or housing accommodations at post-secondary institution.

The information is to be provided to:

Student Disability Services, Braniff

- ○ Other (please describe):

_____

e. Severity of symptoms

- ○ Mild
- ○ Moderate
- ○ Severe

f. Prognosis of disorder:

- ○ Good
- ○ Fair
- ○ Poor

Please b

b. Please check the functional limitations or behavioral manifestations for this student:

b. Recommended accommodations. Please provide a rationale for each accommodation. In the absence of a rationale, Student Disability Services may be unable to recommend the proposed accommodation:

_____

_____

_____

_____

c. Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

_____

_____

d. **COURSE LOAD REDUCTION**: Is the student's condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

- ○ Yes
- ○ No
- ○ I don't know

If YES please explain: _____

_____

_____

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document. All documentation submitted to SDS is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature:_____Date:_____

Print name and title:_____

_____

State of License :_____ License Number: _____

Address:_____

_____

Street or P.O. Box City State Zip

Phone:_____Fax:_____

Please return this form to:

University of Dallas
Student Disability Services
Academic Success Office 1845 East
Northgate Drive Irving, Texas 75062 Phone:
(972) 721-5056 Facsimile: (972) 265-5712

[Adapted from https://diversity.utexas.edu/disability/wp-content/uploads/2018/07/Medical.VerForm-2015-Updated.pdf, with permission from ITS, The University of Texas at Austin, Austin, Texas 78712-1110.]