UNIVERSITY OF SAN FRANCISCO

CHANGE THE WORLD FROM HERE

Student Disability Services
Gleeson LL 20
2130 Fulton Street
San Francisco, CA 94117
Tel 415.422.2613
Fax 415.422.5906
usfca.edu/sds

Verification of Disability

Must be completed by a licensed health care professional

Student's Name: _____ Date: _____

The student named above has applied for services from the office of Student Disability Services (SDS) at University of San Francisco (USF). In order to determine eligibility and to provide services, we require documentation of the student's disability.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please print it out, sign it, and mail or fax it to us at the address above. The information you provide will not become part of the student's educational records, but will be kept in the student's file at SDS, where it will be held strictly confidential. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

1. **Diagnosis/description of condition.** What is your DSM-5 and/or ICD-10 diagnosis for this student (if appropriate)?

_____

_____

2. **Describe how this condition rises to the level of disability, and how it substantially limits a major life activity** (i.e. thinking, walking, learning, hearing, caring for oneself, etc.):

_____

_____

3. **Circle one**: Psychological Disability Medical Disability

4. **Date of diagnosis**: ____/_____/____

5. **Date student was last seen**: ____/____/____

6. **Please list any academic or other disability accommodations you recommend:**

_____

_____

7. **How did you arrive at your diagnosis?** Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.

√	Criteria	Additional Notes
	Structured or unstructured interview with the student	
	Interviews with other persons	
	Behavioral observations	
	Developmental history	
	Educational history	
	Medical history	
	Neuro-psychological testing: date(s) of testing?	
	Psycho-educational testing: date(s) of testing?	
	Standardized or non-standardized rating scales	
	Other (Please specify):	

8. **Please check which of the major life activities listed below are affected** because of the diagnosis. Please indicate the level of limitation.

Life Activity	No impact	Moderate impact	Severe impact	Don't know
Concentrating				
Memory				
Sleeping				
Eating				
Social interactions				
Self care				
Managing internal distractions				
Managing external distractions				
Timely submission of assignments				
Attending class regularly & on time				
Making and keeping appointments				
Stress management				
Organization				

9. **Is this student currently taking medication(s) for these symptoms?** _____

a. If so, describe the medication(s), date(s) prescribed, effect on academic functioning, and side effects.

_____

_____

b. Do limitations/symptoms persist even with medications? _____

10. **What is the student's prognosis?**

_____

_____

11. **Expected duration of condition/disability:**

○ Permanent/Stationary ○ Fluctuating ○ Temporary (specify approx. # of days____)

12. **How long do you anticipate the student's academic achievement will be impacted by this disability?**

○ 6 months ○ 1 year ○ More than 1 year ○ Other (please specify)_____

13. **Level of Severity (please circle one):**

○ Mild ○ Moderate ○ Severe

14. **What other specific symptoms currently manifesting themselves might affect the student's <u>academic</u> performance?**

_____

_____

15. **Are there any specific symptoms currently manifesting themselves which might affect the student in a <u>non-academic</u> setting** (i.e. on–campus housing, etc.)**?**

_____

_____

16. **Is there anything else you think we should know about the student's disability?**

_____

_____

(Over)

Certifying Professional*

Signature of Professional	Date
Professional's Name (printed) and Title	License No.
Address	Telephone No.
City, State, Zip	Fax

*Qualified diagnosing professionals must have expertise in the differential diagnosis of the documented mental disorder or condition and follow established practices.