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

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. **Check 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?** ________________________________

8a. If so, describe the medication(s), date(s) prescribed, effect on academic functioning, and side effects.
____

____

8b. Do limitations/symptoms persist even with medications? _____________________________________

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

____
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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 academic performance?**
____

____

15. **Are there any specific symptoms currently manifesting themselves which might affect the student in a non-academic 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, Sate, Zip	Fax

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