Idaho State UNIVERSITY

Disability Services
921 South 8th Avenue, Stop 8121 • Pocatello, Idaho 83209-8121
Rendezvous Complex, Room 125

VERIFICATION FORM FOR STUDENTS WITH DISABILITIES

Student/Patient: ____ Date of Birth: __________________________________

Date of last clinical contact with student: ______________________________

DSM-5 or ICD-10 Diagnoses

	Diagnosis	Level of Severity (mild to severe)	Age of Onset	Prognosis
1.	________________	________	______	________
2.	________________	________	______	________
3.	________________	________	______	________
4.	________________	________	______	________
5.	________________	________	______	________

Functional Limitations

Functional limitations should be determined without consideration of mitigating measures, such as medication. If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms. Does this condition **significantly limit one or more of the following major life activities**? Check all that apply and **circle level of impact** (moderate to substantial):

- ☐ Communicating (moderate/severe)
- ☐ Concentrating (moderate/severe)
- ☐ Hearing (moderate/severe)
- ☐ Learning (moderate/severe)
- ☐ Manual Tasks (moderate/severe)
- ☐ Reading (moderate/severe)
- ☐ Seeing (moderate/severe)
- ☐ Thinking (moderate/severe)
- ☐ Walking (moderate/severe)
- ☐ Working (moderate/severe)
- ☐ Other: ______________________ (moderate/severe)

Behavioral Manifestations

Check all that apply and **circle degree of issue** (moderate to substantial):

- ☐ Cognitive Processing (moderate/substantial)
- ☐ Memory (moderate/substantial)
- ☐ Processing Speed (moderate/substantial
- ☐ Meeting Deadlines (moderate/substantial)
- ☐ Attending Class (moderate/substantial)
- ☐ Organization (moderate/substantial)
- ☐ Reasoning (moderate/substantial)
- ☐ Stress (moderate/substantial)
- ☐ Sleep (moderate/substantial)
- ☐ Appetite (moderate/substantial)
- ☐ Other: ______________________ (moderate/substantial)
- ☐ Other: ______________________ (moderate/substantial)

Recommended Academic Accommodations

Based on your **diagnoses for this student, their functional limitations, behavioral observations, interviews, and testing**, check all of the following that you would recommend we consider as academic accommodations:

- ☐ Reduced Course Load
- ☐ Note-taking Services
- ☐ Recording Lectures
- ☐ Reader for Exams
- ☐ Service Animal
- ☐ Large Print
- ☐ Assistive Technology
- ☐ Private Testing Room
- ☐ Assistive Listening Device
- ☐ Transcription
- ☐ Copy of Professor Notes
- ☐ Accessible Housing
- ☐ Extra Time on Tests
- ☐ Reduced Distraction Testing Room
- ☐ Preferential Seating
- ☐ Large Print
- ☐ Flexibility with Attendance/Assignments: Explain ____
- ☐ Other: ____________________

Please fax this form and any supporting documentation of diagnoses and testing to our office at (208) 282-4617.

Provider Name: ____________________________________ Title: ________________________ Date: _____________________

Signature: ____ Phone: _______________________ Fax: _____________________