Disability Verification
(to be completed by diagnosing or treating psychologist/physician or licensed diagnostician)

Disability Support Services (DSS) at Stark State College provides services to students with diagnosed disabilities. To ensure reasonable accommodations are provided our students, this office requires documentation from their diagnosing or current physician/psychologist. This should include information on functional limitations as they may relate to the educational setting, severity of the condition, treatment and/or prescribed medication if it impacts education, and recommendations for accommodations.

Accommodations and services are based on a review of this information, in accordance with criteria established in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act Amended. The information provided will not become part of the student’s academic record, and confidentiality will be maintained. Please feel free to contact the Disability Support Services office with any questions or concerns you may have regarding the information you are being asked to provide. Thank you for your assistance.

Student Name: ___________________________ DOB: ___________________________

1. Diagnosis: ________________________________________________________________
____________________________________________________________________________

Level of Severity (circle one): Mild  Moderate  Severe

Date of Diagnosis: _____________________________________________________________

Last contact with student: ____________________________________________________
2. Describe the particular symptoms of the disability that manifest most significantly for this student: __________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

3. List current medications that may have adverse side effects as they impact the educational setting:
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

4. List other treatment recommendations that may impact the educational setting:
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

5. List any recommendations for accommodations you may have for this student in an academic setting (i.e. extra time for exams, distraction-free testing space, audio text books, electric scooter, assistive listening devices, front row seating, etc.):
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
6. Describe any other relevant information you may wish to share about this student, as it pertains to ways that we may be of further assistance:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Signature of Physician/ Psychologist, or Licensed Diagnostician: ______________________

Printed Name and Title: ____________________________________________________________

Address: ____________________________________________________________

City: __________________________ State: __________ Zip: ______

Phone: (_____ ) __________________________

Email address (if applicable): __________________________

Please have Doctor’s office mail, e-mail or fax this completed form to:

Stark State College
Disability Support Services
6200 Frank Ave. NW
North Canton, Ohio 44720-7299
(330) 494-6170 Ext. 4935
Fax (330) 497-6313
Attn: Disability Support Services
E-mail: disabilityservices@starkstate.edu

NOTE: Please Fax to Attention: Disability Support Services.