Disability Support Services
6200 Frank Ave. NW
North Canton, Ohio 44720-7299
(330) 494-6170 Ext. 4935
Fax (330) 305-6629
E-mail: disabilityservices@starkstate.edu

Disability Verification Form

Disability Support Services (DSS) provides support services that provide equal access for students with diagnosed disabilities. To ensure reasonable accommodations are provided our students, this office requires documentation from their diagnosing or current physician/psychologist. Accommodations and services are based on a review of this information, a meeting with the student, and criteria established in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act as Amended. The information provided will not become part of the student's academic record, and confidentiality will be maintained.

Appropriate documentation should include, but is not limited to, the following:

1. **Completed by a licensed professional and/or properly credentialed professional** (e.g. medical doctor, psychiatrist, psychologist, clinical counselor, speech-language pathologist, etc.). DSS does not accept documentation completed by diagnosing /treating professionals related to the student requesting accommodations.

2. **All parts of the disability verification form should be completed as thoroughly as possible**. Where appropriate, summary and data from specific test results should be attached. If a comprehensive diagnostic report is available that provides the requested information, it can be submitted in lieu of the disability verification form.

3. **A mental health diagnosis should include the diagnosis as based on the DSM V.** Documentation must be current. Initial documentation must be based on evaluations performed within 1 year unless the student has remained in clinical contact with his or her evaluator. All documentation must describe the current impact of the diagnosed impairment(s) and describe medication and treatment modalities.

4. **The information provided on the disability verification form is maintained by DSS according to the guidelines of the Family Education Rights and Privacy Act (FERPA) of 1974**. This information may be released to the student upon their written request.

Please contact Disability Support Services at (330) 494-6170 ext. 4935 with questions.
Thank you for your assistance.

STUDENT INFORMATION
(to be completed by student)

First Name: _____ Last Name: _____

Phone: (_____) _____ - _____ DOB _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize the following individual or organization to release the information included in this document to Disability Support Services at Stark State College:

Student Signature: _____ Date: _____

DIAGNOSTIC INFORMATION
(to be completed by medical practitioner/specialist)

1. Please specify the specific diagnosis/disability: _____

_____

DSM-5 or ICD Diagnosis & Code: _____

_____

If applicable, please rate the level of severity of the student's diagnosis?

☐ Mild ☐ Moderate ☐ Severe

Duration of condition: ☐ Permanent ☐ Temporary (specify length of time) _____

Date of Diagnosis: _____ Date of last contact with student: _____

2. How did you arrive at your diagnosis? Please check all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

☐ Behavioral Observations/ Development History
☐ Medical History
☐ Rating Scales (e.g., CAARS, Brown ADD Scales for Adults
☐ Other (please specify): _____

_____

☐ Neuro-Psychological Testing, Date(s) of Testing _____
☐ Psycho-Educational Testing, Date(s) of Testing _____
☐ Structured/unstructured interviews with Person

3. Describe the particular symptoms of the disability that manifest most significantly for this student:

_____

_____

_____

4. Please describe current treatment protocol, including current medications and possible side effects.

_____

_____

_____

5. Based on your professional knowledge of the diagnosis, list any suggested accommodations you have for this student in an academic setting.

_____

_____

_____

6. Please provide any additional information that you think would be useful to know in working with this student.

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon written request.

Provider Name (PRINT): _____

Provider Signature: _____ Date: _____

Title: _____ License or Certification #_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Email address (if applicable): _____

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

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