

Office of Disability Services

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WWW.csuohio.edu/disability/

Physical and Mobility Disability Verification Form

The Office of Disability Services (ODS) provides academic services and accommodations for student with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show the functional limitations that impact the individual in the academic setting.

The ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Cleveland State University generally requires documentation prepared within the past three years. The University reserves the right to request updated or more extensive evaluations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare profession(s) in obtaining specific information necessary to evaluate eligibility for academic accommodations.

- The healthcare profession(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are trained, certified or licensed orthopedists, neurologists, rehabilitation specialists, or other medical professionals.
- All parts of the form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional related information. If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.
- After completing this form, sign it, complete the healthcare Provider Information section, on the last page, and mail or FAX it to us at the address provided above. The information that you provide will NOT become part of the student's educational records, but it will be kept in the student's file at ODS, where it will be held strictly confidential.

STUDENT INFORMATION

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Last 4 digits of SSN _____

Local Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Address (street, city, state, and zip code): _____

Diagnostic Information

1. Diagnosis: _____

2. Date of first contact with student: _____

3. Date of last contact with student; _____

4. Is the student currently under your care? ___ YES ___ NO

5. Describe the **functional limitations** associated with this disability:

6. Describe the **progression of the student's condition**, if applicable:

7. Describe how this condition substantially limits a major life activity and how it may impact the student's progress in an academic setting:

8. List the **current medication(s), dosage, frequency, and possible adverse side effects** as related to academic performance:

9. List **other treatment(s)** the student is receiving to manage his/her disability:

10. List any recommendations for accommodations that you have for this student in an academic setting:

HEALTHCARE PROVIDER INFORMATION

Please sign and date below and fill in all other fields completely. Please print or type.

Provider's signature: _____ Date: _____

Provider's name (print): _____

Title: _____

License or Certification #: _____

Address:

Phone number: (____) _____ - _____ FAX number: (____) _____ - _____