Office of Disability Services

2121 Euclid Avenue MC 147
Cleveland, Ohio 44115-2214
Phone: (216) 687-2015
FAX: (216) 687-2343
www.csuohio.edu/disability

Neurological Disability Verification Form

The office of Disability Services (ODS) provides academic services and accommodations for students 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 an 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 last three years. The University reserves the right to request updated or more extensive evaluation. The outline below has been developed to assist the student working with the treating or diagnosing healthcare professional(s) in obtaining specific information necessary to evaluate eligibility for academic accommodations.

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained***, certified, or licensed neurologists, neurosurgeons, orthopedists, or endocrinologists.***
- All parts of this form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional, related 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 the address provided above. The information that you provide will NOT become part of the student's educational record, but will be kept with 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 ____________

Status (darken one) ⬭ current student ⬭ transfer student ⬭ prospective student

Local Phone (___) _____-_______ Cell Phone: (___) _____-_______

Address (street, city, state and zip code)

____

Diagnostic Information

1. Diagnosis: ____
2. Date of first contact with the student: ____
3. Date of Last Contact: ____
4. Is the student currently under your care? _____ Yes _____No
5. What is the severity of the disorder? _____Mild _____Moderate _____Severe

   Please describe the severity indicated above:

   ____

   ____

   ____
6. What is the expected duration of this disability?

   ____

   ____

   ____
7. Describe the symptoms associated with this condition?

   ____

   ____

   ____

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

   ____
   ____
   ____
   ____

9. List ***any other treatment*** that the student is receiving to manage his/her condition:

   ____
   ____
   ____
   ____

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

    ____
    ____
    ____
    ____
    ____

11. List any ***recommendation 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: (___) _____-______