Schoolcraft College® | DISABILITY SUPPORT SERVICES

Disability Verification Form

Disability Support Services at Schoolcraft College provides services to students with disabilities. The student named below may be eligible for services offered through this office. The purpose of this form is to ensure our office has record of a student's relevant disability information that may aid in the exploration of the reasonable accommodations.

Information shared with this office is confidential. All records are stored in the Disability Support Services Office at Schoolcraft College and are not part of the student's academic record.

To be completed by student:

Student Name:_____

SC Student Number: _____ Date of Birth: _____

I authorize the release of the information requested to Disability Support Services at Schoolcraft College

_____ _____

Signature Date

To be completed by licensed medical professional:

This section is to be completed by a fully licensed health care professional who has first-hand knowledge of the student's disability, such as the treating or diagnosing physician, psychiatrist, psychologist, social worker, counselor, therapist or other qualified medical professional who is licensed to diagnose.

1. Primary Diagnosis: _____

   DSM/ICD Code: _____ Level of severity: ❑Mild ❑Moderate ❑Severe

   Date of diagnosis: _____ Is this a permanent disability: ❑Yes ❑ No

2. Secondary Diagnosis (if applicable):_____

   DSM/ICD Code: _____ Level of severity: ❑Mild ❑Moderate ❑Severe

   Date of diagnosis: _____ Is this a permanent disability: ❑Yes ❑ No

3. Date of last office visit: _____

4. Medication prescribed: _____

See Page 2

Implications for Educational Success:

5. Assessments or evaluation tools used to diagnose. Please attach report, if available. (e.g. MMPI-2, BAI, BDI-II, ASRS, WAIS, WIAT, diagnostic interview): _____

_____

6. Functional limitations on learning abilities in higher education environment (e.g. processing, concentrating, memory, managing distractions, etc.): _____

_____

_____

_____

7. Functional limitations on exams and classroom activities in higher education environment (e.g. test taking, note taking, etc): _____

_____

_____

_____

8. Please list specific accommodations or services to address the functional limitations identified:

_____

_____

_____

I certify that the above referenced patient/client has a "physical or mental impairment that substantially limits one or more of the major life activities of such an individual" as defined by the Americans with Disabilities Act. In addition, I have the necessary professional qualifications to document my patient/client's disability and the information provided on this form is accurate to the best of my ability.

Name of Professional (Please print): _____

Signature of Professional: _____

License #: _____

Date: _____

Address: _____

_____

Phone: _____

Fax: _____

Please staple your business card here.