

## Disability Verification Form

The [Center for Disability Services \(SNAP\)](#) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis 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, and the Amendments Act of 2008. The ADA/ADAAA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (e.g. psychiatrist, psychologist, counselor, therapist, social worker, medical doctor, optometrist, speech-language pathologist) in obtaining the specific information to evaluate eligibility for academic accommodations.

- A. **The healthcare/treatment provider conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified, or licensed to diagnosis medical conditions. Please see our [Criteria for Documentation Disabilities](#) for specific qualifications per disability type.
- B. **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow-up contact for clarification.
- C. **The healthcare/treatment provider should attach any reports, which provide additional related information** (e.g. psychoeducational assessments, neuropsychological test results). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation in lieu of this form. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.
- D. **The information provided on this form will be kept in the student's file at the Center for Disability Services, where it will be held securely and confidentially.** This form may be released to the student at his/her request.

If you have questions regarding this form, please call the Center for Disability Services at 843-953-1431 or email [SNAP@cofc.edu](mailto:SNAP@cofc.edu). Thank you for your assistance.

**STUDENT INFORMATION**  
**(To be completed by student)**

Student Name: \_\_\_\_\_

CofC Student ID Number : \_\_\_\_\_

**I authorize College of Charleston to receive information from the provider listed below. I also authorize my provider to discuss my disability(ies) with the appropriate College personnel to make a proper determination of necessary accommodations. My signature also indicates that the appropriate healthcare provider or their designee has completed the statements and documentation.**

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DIAGNOSTIC INFORMATION**  
**(To be completed by treatment provider)**

**(Please type or print clearly)**

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Date of your last contact with the student: \_\_\_\_\_

What instrument/procedures were used to diagnose the disability?

<b>X</b>	<b>Instrument/Procedure</b>	<b>Additional Notes</b>
	<b>Interviews with the student</b>	
	<b>Interviews with other persons</b>	
	<b>Developmental history</b>	
	<b>Behavioral Observations</b>	
	<b>Educational history</b>	

	<b>Other tests, etc.:</b>	
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Please describe the presenting symptoms of this disorder and your on-going relationship regarding the student's treatment plan.

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Please identify the functional limitations listed below and indicate the level of limitation.

<b>X</b>	<b>Life Activity</b>	<b>No Impact</b>	<b>Moderate to Severe Impact</b>	<b>Uncertain</b>
	<b>Learning</b>			
	<b>Concentrating</b>			
	<b>Memory</b>			
	<b>Sleeping</b>			
	<b>Eating</b>			
	<b>Social Interactions</b>			
	<b>Managing Internal Distractions</b>			
	<b>Managing External Distractions</b>			
	<b>Timely Submission of Assignments/Tasks</b>			
	<b>Regular and Timely Attendance</b>			
	<b>Making and Keeping Appointments</b>			
	<b>Managing Stress</b>			
	<b>Organizing</b>			
	<b>Other:</b>			

In addition to the major activities listed above, please describe activities that may be impacted by the disability or symptoms that may need to be addressed in the college environment.

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Is the student currently taking medication for this disability? \_\_\_Yes \_\_\_No

If yes, what is the medication?

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Please describe any side effects of the medication.

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**ACCOMMODATION RECOMMENDATIONS (To be completed by treatment provider):**

Please state specific recommendations regarding academic and/or housing accommodations for this student.

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Extended exam time

Limited distraction environment for exams

Other: \_\_\_\_\_

How long do you anticipate the student will be impacted by this disability?

Six Months

One Year

Ongoing

**ADDITIONAL INFORMATION and PROVIDER CREDENTIALS**

**(To be completed by treatment provider):**

Please attach any additional documentation that you believe to be relevant (e.g. psychological assessment, neuropsychological test results, Individualized Education Program, audiogram, vision evaluations, etc.).

Signature \_\_\_\_\_

Print Name and Title \_\_\_\_\_

License # \_\_\_\_\_

Agency Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Phone \_\_\_\_\_

Date \_\_\_\_\_

**Return form to:**

Center for Disability Services  
66 George Street LCTR 104  
Charleston, SC 29424

Phone: 843 953 1431  
Fax: 843 953 7731  
Email: snap@cofc.edu