COLLEGE of CHARLESTON

CENTER FOR DISABILITY SERVICES

Disability Verification Form

The Center for Disability Services (SNAP) provides academic services and accommodations for students with disabilities. The documentation provided regarding the disability must illustrate 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 their request.

If you have questions regarding this form, please call the Center for Disability Services at 843-953-1431 or email 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?

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

	Other tests, etc.:	

Please **describe** the presenting symptoms of this disorder.

_____

_____

What is your treatment plan for this student?

_____

_____

Please describe the functional limitations to the life activities listed below, and indicate the degree of limitation.

Life Activity	
Learning	
Concentrating	
Memory	
Sleeping	
Eating	
Social Interactions	
Managing Internal Distractions	
Managing External Distractions	
Timely Submission of Assignments/Tasks	
Regular and Timely Attendance	
Making and Keeping Appointments	
Managing Stress	

Organizing	
Other:	

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.

_____

_____

Is the student currently taking medication for this disability? ___Yes ___No

If yes, what is the medication?

_____

Please describe any side effects of the medication.

_____

ACCOMMODATION RECOMMENDATIONS (To be completed by treatment provider):

Please state specific recommendations regarding academic accommodations for this student.

_____

_____

_____

___ 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