



CHICAGO STATE UNIVERSITY

Abilities Office of Student Services

9501 South King Drive
CRSUB, Suite #160
Chicago, Illinois 60628

Verification of Disability

In order to establish that a student is an “otherwise qualified student with a disability,” the Abilities Office of Chicago State University, in accordance with the Americans with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973 (504), is requesting documentation of a disability. This student has requested services related to his/her disability from the Abilities Office and has stated that you are an appropriate individual to provide this disability documentation.

Directions: This form is to be completed by a **licensed treating professional or certified diagnostician**. Please complete this form in order to document that this student does indeed have a disability that substantially limits learning and/or some other major life activity. Please thoroughly answer all questions in as much detail as possible, as this will provide the Abilities Office with information that is needed to advocate for this student. **You may type your response directly into this document.** If you need additional space, please feel free to write or type on a separate sheet of paper.

Thank you for your assistance.

1. **Student’s First & Last Name:** _____

2. **What is the diagnosis/impairment?** (Include DSM classifications, if appropriate.)

Dx: _____

Diagnostic code(s): _____

a. **Date:** When was the diagnosis made? _____

b. **Contact:** Date of last contact with this student? _____

c. **Appointment:** Date of next appointment or timeframe for next contact?

3. **Tests:** What tests or criteria, if any, were relied upon in reaching the diagnosis identified in question 2?

4. **Prognosis:** *(Include the severity of the diagnosis and your evidence that the student's disability will cause a substantial limitation to learning and/or other major life activities)*

a. Is the impairment/condition permanent? _____ **YES** _____ **NO**

b. If not, what is the prognosis? _____

5. **Symptoms:** Describe the symptoms associated with this medical condition.

6. **Functional Limitations:**

a. Describe how this medical condition may affect this student both academically and/or physically? Please indicate strengths and weaknesses.

b. Does this impairment affect major life activity? _____ **YES** _____ **NO**

c. If yes, what major life activity/activities is/are affected?

_____ Caring for self	_____ Walking	_____ Hearing	_____ Lifting
_____ Interaction with others	_____ Standing	_____ Seeing	_____ Sleeping
_____ Performing Manual Tasks	_____ Reaching	_____ Speaking	_____ Concentrating
_____ Breathing	_____ Thinking	_____ Learning	_____ Working
_____ Toileting	_____ Sitting	_____ Reproduction	_____ Other:

7. **Medications:** Please list current medications and identify any adverse side effects to medication which may impede this patient's ability to function academically.

8. **Therapy:** For mental health diagnoses, please document if counseling services (i.e. talk therapy/psychotherapy, individual or group services, cognitive-behavior therapy, etc.) is used as a treatment modality?

9. **Recommendations:** Please recommend accommodation(s) which may assist the student in performing academic requirements.

10. **History:** Please provide any chronological information which may be relevant to this student's disability.

11. **Comments:** Any additional information that can assist in providing appropriate services for this student.

Provider's Signature _____ Date _____

Print Provider's Name: _____ Title/License#: _____

Provider's Address: _____

Provider's Phone: _____ Fax: _____

Student Release of Medical Information

I authorize my physician or professional clinician to release information pertaining to my diagnosis to the Abilities Office of Student Services at Chicago State University, for the purpose of supporting my request for accommodations due to my disability.

Student Signature _____ Date _____

Witness _____ Date _____

After completing this form, please return it to the Abilities Office at the above address, email it to abilities@csu.edu or fax it to 773-995-3563. Please contact the Abilities Office at 773-995-2380 if you have questions about this form.