Disability Identification and Verification Form

The Taylor College Dean's' and Compliance Office 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. 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 functional limitations that impact the individual in the academic setting.

Taylor College requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

A. **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 psychologists or members of a medical specialty.
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 provider should attach any reports which provide additional related information** (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Please do not provide case notes or rating scales without a narrative that explains the results.
D. **After completing this form, sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to the College.** The information you provide will not become part of the student's educational records, but it will be kept in the student's file at the, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

If you have questions regarding this form, please call the Academic Dean's or Compliance Office, or stop by and make an appointment. Thank you for your assistance.

STUDENT INFORMATION

Name (Last, First, Middle): _____

Date of Birth: _____ Last 4 Digits of SSN: _____

Cell phone: (_____)-_____-_____ Home phone: (_____)-_____-_____

Address (street, city, state and zip code): _____

E-Mail address: _____

DIAGNOSTIC INFORMATION

(Please Print Legibly or Type)

1. What is the diagnosis, date of diagnosis, and last contact with the student?

_____
_____
_____

2. Is the student/patient currently under your care? Yes / No (Please circle the correct response)

_____
_____
_____

3. List current medications(s), impact, and adverse side effects.

_____
_____
_____

4. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically.

_____
_____
_____

5. Major Life Activities Assessment: Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

Major Life Activity	1–Negligible	2-Moderate	3-Substantial
Talking			
Hearing			
Breathing			
Standing			
Caring for Oneself			
Reaching			
Lifting			
Sitting			
Walking			
Seeing			
Writing			
Performing Manual Tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Memorizing			
Interacting with Others			
Other:			
Other:			
Other:			
Other:			

6. Describe how this medical condition may result in specific functional limitations in an academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, or unable to walk more than 50 feet without fatigue)?

_____

_____

_____

7. What is the expected duration of this disability?

_____

_____

_____

8. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and fill in all other fields completely using PRINT or TYPE) all other fields completely using PRINT or TYPE)

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____

License or Certification #: _____

Address:

_____

_____

Phone Number: (_____)-_____-_____ FAX Number: (_____)-_____-_____

Important: After documentation is reviewed, the Academic Dean, Compliance Officer or his/her designee will send an email notification to the student's email account, acknowledging receipt of documentation and the eligibility status. Prospective students that do not have an email account will be notified via telephone.