ACCESSIBILITY
RESOURCE
CENTER

Diagnosis Verification Request

Student Name:______________________________________ DOB#: ______________________

This part of the form is to be completed by the student:

Describe how the disability substantially limits your major life activities:

____

____

State the impact and specific functional limitations relating to your academic performance: ____

____

____

____

This part of the form is to be completed in full by a licensed professional:

Diagnoses (Including ICD/DSM-IV codes): Date:

1.____ ____________________

2.____ ____________________

3.____ ____________________

Severity: ☐Mild ☐Moderate ☐Severe ☐Partial remission ☐Residual state

Condition: ☐ Permanent ☐Temporary until ______________

Date of last visit:________________

Continue to second page.

List current medications:

Medication	Dosage	Frequency	Patient Reported Side Effects

Practitioner Comment (if applicable): ____

____

____ ____________________

Signature of Licensed Professional Date of Verification

____ ____________________

Print Name/Title License Number

____ ____________________

Address Phone Number