ARC Diagnosis Verification Request

Student Name:_____ **DOB**:_____

UNM ID#:_____ **Email**:_____

PART A: 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:

_____

_____

_____

PART B: to be completed in full by a licensed professional.

Diagnoses (Including ICD/DSM-V codes): **Date:**

1._____ _____

2._____ _____

3._____ _____

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

Condition: ☐ Permanent ☐ Temporary until _____ **Date of last visit:**_____

List current medications (if applicable):

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

Accessibility Resource Center
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