Office of AccessAbility Services
Disability Verification Form

The student named below has asked to register with the Office of AccessAbility Services (OAS) at Goodwin University. OAS requires documentation of the student's disability in order to establish eligibility and provide services. Documentation must include a medical or clinical diagnosis of the disability based on ICD Codes and/or the DSM-5 and a rationale for the diagnosis.

This evaluation form must be completed by a licensed health professional.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. **To establish that an individual is covered under the law, documentation must indicate that a disability exists and that the disability substantially limits one or more major life activities. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and academic adjustments.**

The information you provide will not become a part of the student's educational records but will be kept in the student's file at OAS where it will be kept confidential. Please contact Molly Zatony, AccessAbility Coordinator at mzatony@goodwin.edu or 860-727-6718 with any questions or concerns. Thank you for your assistance.

All documentation is considered confidential and can be sent to:

ATTN: Molly Zatony, AccessAbility
One Riverside Drive
East Hartford, CT 06118

Fax: 860-913-2196

Goodwin University

OASDV

Office of AccessAbility Services Disability Verification Form

Student Name: _____

FOR THE CURRENT TREATING HEALTHCARE PROVIDER TO COMPLETE

Date of Diagnosis: _____

Date of your last clinical contact with student: _____

Please list all DSM-5 and/or ICD Diagnoses _____

Are there any coexisting conditions, including medical disabilities, emotional/psychological, or learning disabilities that should be considered when providing accommodations? _____

EVALUATION

How did you arrive at this diagnosis?

- ☐ Structured or unstructured interviews with student
- ☐ Interviews with other persons (i.e. parent, teacher, therapist)
- ☐ Behavioral observations.
- ☐ Developmental history
- ☐ Educational history
- ☐ Medical history
- ☐ Neuropsychological testing
- ☐ Psychoeducational testing
- ☐ Medical testing
- ☐ Ratings scales

☐ Other (please specify) _____

FUNCTIONAL LIMITATIONS

Please check below the major college life activities that are affected to a substantial degree because of the disability:

- ☐ Eating
- ☐ Sleeping
- ☐ Learning
- ☐ Organization
- ☐ Focus or concentrating
- ☐ Memory
- ☐ Reading
- ☐ Writing
- ☐ Testing
- ☐ Regular class attendance
- ☐ Managing deadlines
- ☐ Stress management
- ☐ Classroom group functioning
- ☐ Social interactions

☐ Other (please specify) _____

Describe current symptoms that impact the individual's ability to perform in a college setting, including attendance:

What is the student's prognosis? How long do you anticipate the student's performance in a college setting will be impacted by the disability?

Past Accommodations: (K-12, prior institutions, CollegeBoard, etc.) Please describe if applicable:

Suggested Accommodations: Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis.

(Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

PROVIDER INFORMATION

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: Date:

Print Name and Title:

State of License: License Number:

Address:

City State Zip:

Phone: Fax: