COLLEGE of CHARLESTON

CENTER FOR DISABILITY SERVICES

DISABILITY VERIFICATION FORM

Student Information (to be completed by the student)

Name: ____________________ CWID: ________________ CofC Email: ________________

I hereby authorize the release and exchange of the following information to the Center for Disability Services (CDS) at the College of Charleston. I understand that relevant information obtained may be shared with other College offices that may be involved in assisting with the establishment of reasonable accommodations.

Signature: ______________________________________ Date: __________________________

Provider Information (to be completed by the provider)

Name: ______________________________ Title: ______________________________

License No: __________________________ State of Licensure: ______________________

Address: ____

Phone: _____________________________ Fax: _______________________________

I, the undersigned, certify that the information provided for the student is true and correct to the best of my knowledge. I confirm that I am licensed or otherwise qualified to diagnose the conditions listed below, have adequately evaluated the student, can produce record of such evaluation, and am not related to the student by blood or marriage.

Signature: ______________________________________ Date: __________________________

Disability Information (to be completed by the provider)

Provide complete answers for all questions. Incomplete documentation will delay a student from registration and access to accommodations. If you are unable to provide a response for a question, please indicate the reason.

Is the student currently under your care? ☐ Yes ☐ No

Diagnosis (include DSM-V Code, if applicable): ______________________ **Date of Diagnosis:** ____________

☐ Permanent/Chronic ☐ Episodic: Typical time between flare-ups: ______________________

☐ Temporary (60 days or less) ☐ Short-Term (60-90 days) ☐ Long-Term (3-12 months)

Severity: ☐ Mild ☐ Moderate ☐ Severe

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Additional Diagnoses (attach additional pages as needed):

160 Calhoun Street • Charleston, South Carolina 29424 • TEL 843.953.1431 • FAX 843.953.7731 • EMAIL snap@cofc.edu

Diagnostic Criteria. List any diagnostic assessments used in making this determination. Examples may include, structured/unstructured interviews, documentation review, observations, rating scales, etc.

List any medication(s), current treatment(s) and/or therapy the student is receiving: ☐ N/A
List should include any mediating effects and potential side effects.

Describe the symptoms relating to this diagnosis that affects the student's participation in the campus community. Examples: heart palpitations, fidgets or squirms in chair, low blood sugar, etc.

According to the Americans with Disabilities Amendments Act, major life activities may include but are not limited to the following, please check all that are **substantially** impacted by the physical or mental impairment of the student. **A substantial limitation is a symptom that has persisted to a degree that is maladaptive and inconsistent with developmental level:**

- ☐ Eating
- ☐ Sleeping
- ☐ Seeing
- ☐ Hearing
- ☐ Speaking
- ☐ Breathing
- ☐ Walking
- ☐ Standing
- ☐ Lifting
- ☐ Self-Care
- ☐ Thinking
- ☐ Learning
- ☐ Reading
- ☐ Communicating
- ☐ Memory
- ☐ Organization
- ☐ Motivation
- ☐ Concentrating
- ☐ Stress Management
- ☐ Performing Manual Tasks
- ☐ Managing Internal Distractions
- ☐ Managing External Distractions
- ☐ Social Interactions
- ☐ Putting Thoughts to Words
- ☐ Operation of a Major Bodily Function:
  - ☐ ______________________________
  - ☐ ______________________________

Given the symptoms and functional limitations noted above, please share any recommended accommodations and the rationale connecting the accommodation to the functional limitation.
Example: Student should take exams in a separate location because the student's anxiety is exacerbated by being in a crowded room, and this impairs concentration.

Completed form can be submitted directly to the Disability Resource Center by **email, fax or returned to the student for submission**.

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