The University of Vermont

ACCESS/Academic Support Programs
Disability Verification for Students with Sensory, Systemic/Chronic or Other Disabilities

The student listed below is seeking disability-related services and accommodations at the University of Vermont. In order to establish eligibility, the student must provide current, comprehensive documentation that establishes the diagnosis(es) and describes the impact on major life activities, particularly learning.

To best understand our overall Documentation Guidelines and before completing this form, please visit:

http://www.uvm.edu/access/?Page=docguidelines/docuguidelines.html&SM=docguidelines/docsubmenu.html

Students whose conditions create a substantial or severe limitation to learning or other major life activities may request modifications or accommodations to courses, programs, or activities at UVM.

This form should be completed by an appropriate licensed professional, such as the diagnosing Medical Practitioner, or Specialist. [Such as, but not limited to: an MD - Audiologist, Neurologist, Endocrinologist, etc.]

Consultation on what information to provide is available. Contact: Laurel.Cameron@uvm.edu

Student completes this section:

Permission to release information to University of Vermont

Signed: _____ **Date:** _____ /_____ /_____

Name: (please print) _____ **UVM Student ID:** _____

Permanent Address:

_____

_____

Campus Address (if applicable):

_____

_____

Phone:

_____

Phone:

_____

Professional completes this section:

Disability History/Diagnostics:

Diagnosis:

_____

Date of diagnosis: _____/_____/_____

Level of Severity (circle one): Mild Moderate Severe

Describe procedures used to establish diagnosis:

_____

_____

_____

Describe symptoms or test findings that meet criteria/support this diagnosis and approximate date of onset:

_____

_____

_____

Disability History/Diagnostics [continued]:

If this student has previously been identified as disabled, describe services provided:

_____
_____
_____

Describe the student's functional limitations in an educational setting and degree to which functioning is impaired; please include information about the impact of medication side effects, if relevant:

_____
_____
_____

Describe procedures you used to assess these limitations:

_____
_____
_____

Medication/Treatment/Equipment:

Length and type of treatment:

_____
_____
_____

Has the student been hospitalized and/or used alternative methods and treatments for this disorder? If so, please provide specifics, approximate dates and/or length of stay as related to the environment of Higher Education:

_____
_____
_____

Is the student currently using medication? Yes _____ No _____

If student is using medication, please provide medication history:

_____
_____
_____

Will student require local treatment/follow-up? Yes _____ No _____

If yes, have arrangements been made? Yes _____ No _____

Does the student need services and accommodations when utilizing recommended treatment? Yes _____ No _____

Is the student utilizing any necessary equipment in relation to their ability to function in an academic setting? If so, please list and include specifics:

_____
_____
_____
_____

Are there anticipated barriers [physical or otherwise] related to this student's ability to function in an academic setting? If so, please list and include specifics:

_____
_____
_____
_____

Medication/Treatment/Equipment:

Date of last clinical contact with student: _____/_____/_____

Recommendations/Additional Information:

Please list specific recommendations (based upon assessment, the student's clinical and academic history, functional limitations and diagnosis) for accommodations and/or support services that you believe will equalize the student's ability to access the University of Vermont's educational program.

_____
_____
_____
_____

Please provide any additional relevant information [such as diagnostic reports, etc.] you feel will be useful in determining the nature and severity of this student's disability, and any additional recommendations that may assist ACCESS in determining reasonable and appropriate accommodations and interventions.

_____
_____
_____
_____

Signature: _____ Date: _____ /_____ /_____

Name, Title (please print): _____

Area of Specialty: _____

State of License: _____ **License Number:** _____

Phone: _____ **Fax:** _____

Address:

_____

Please return this form to:

ACCESS, Disability Services
A170 Living/Learning Center
University of Vermont
Burlington, Vermont 05405-0396
Phone: (802)656-7753 **FAX: (802)656-0739**
Email: access@uvm.edu