COLUMBIA COLLEGE
Student Success
Accessibility · Advising · Career

DISABILITY VERIFICATION FORM

Student Information (to be completed by the student)

Name: _____ CC ID#: _____ CC Email: _____

I hereby authorize the release and exchange of the following information to the Accessibility Services at Columbia College. 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

Is this a student request or a medical recommendation based on exhaustive treatment plans?

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. If an animal is requested, please explain the nexus between the student and the animal.

Describe the symptoms relating to this diagnosis that affects the student's participation in the campus community.

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.

Completed form can be submitted directly to Accessibility Services by **email at** accommodations@columbiasc.edu or 803.786.3342.