Department for Disability Support Services
Suite 109 Mendenhall | Mail Stop 416 | East Carolina University | Greenville, NC 27858-4353
252-737-1016 voice | **252-737-1025** fax

Disability Verification Form

Student Information (to be completed by the student.)

Name: _____ Banner ID: _____ Date of Birth: _____

By my signature below I hereby authorize my health care provider _____ to furnish the following information to the Department of Disability Support Services (DSS) at East Carolina University. I understand that relevant information obtained may be shared with other University offices that may be involved in assisting with the establishment of reasonable accommodations.

Signature: _____ Date: _____

Provider Information (to be completed by the provider, provider should not be related to the student.)

Name: _____ Title: _____

Address: _____

Phone: _____ Fax: _____ License #: _____

I certify that the information below is true to the best of my knowledge.

Signature: _____ Date: _____

Please complete the form below in its entirety. If you are unable to answer a section, or it is not applicable, please mark N/A or provide a description of why you are unable to answer. Please provide responses by typing or writing clearly. Illegible forms will delay the documentation review process.

Disability Information:

Diagnosis: _____ **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

Diagnosis: _____ **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

Additional Diagnoses (please attach additional pages as needed):

_____

_____

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Please describe the symptoms relating to this diagnosis that may affect the student's participation in the campus community. *Examples: heart palpitations, fidgets or squirms in chair, low blood sugar.*

_____

_____

_____

_____

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
- ☐ Stress Management
- ☐ Performing Manual Tasks
- ☐ Operation of a major bodily function
  - ○ _____
- ☐ Social Interactions
- ☐ Learning
- ☐ Reading
- ☐ Concentrating
- ☐ Thinking
- ☐ Communicating
- ☐ Memory
- ☐ Managing Internal Distractions
- ☐ Managing External Distractions
- ☐ Organization
- ☐ Motivation
- ☐ Putting Thoughts to Words
- ☐ Attending Class Regularly

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.*

_____

_____

_____

_____

_____

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Disability Verification Form – Dining Services

East Carolina University's Campus Dining, Student Health Services and Disability Support Services are committed to supporting students with food allergies, gastrointestinal disorders, eating disorders, and any other dietary restrictions as they impact the nutritional options available on campus.

To be completed by the health care provider:

Please indicate which of the following food groups may cause an allergic reaction and indicate the severity:

Food Group:	Mild	Moderate	Severe
Peanuts			
Tree Nuts			
Fish			
Shellfish			
Soy			
Milk			
Eggs			
Wheat			
Other: _____			
Other: _____			

Dietary restrictions imposed by the allergy/disorder, please be specific about what foods that must not be ingested:

_____

_____

_____

_____

_____

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How is the student's ability to utilize dining services impacted by the eating disorder? To what extent?

_____
_____
_____
_____
_____

Recommended Accommodations with Rationale:

_____
_____
_____
_____
_____

Please return form to Disability Support Services via email at DSSdept@ecu.edu or Fax (252) 737-1025