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

Disability Support Services (DSS) is a resource for students with disabilities. The primary role of DSS is to ensure students with disabilities have equitable access to all ECU programs, services, facilities, and activities of the university. DSS works with ECU students, faculty, and staff to coordinate a range of services and accommodations to support students with disabilities on an individualized basis.

Documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (2008). The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (psychiatrist, psychologist, counselor, therapist, social worker, medical doctor, optometrist, speech-language pathologist, etc.) in obtaining specific information to evaluate eligibility for accommodations.

A. The **healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified, or licensed to diagnose medical conditions, and should not be a family member of the student.

B. All **parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow-up contact for clarification.

C. The **healthcare provider should attach any reports which provide additional related information** (e.g. psychoeducational assessments, neuropsychological test results, Individualized Education Programs [IEPs], etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation in lieu of this form. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

D. **The information you provide will be kept in the student's file at ECU DSS, where it will be held securely and confidentially.** This form may be released to the student at their request.

If you have questions regarding this form, please contact:

East Carolina University

Department for Disability Support Services

252-737-1016

dssdept@ecu.edu

ECU
DISABILITY SUPPORT SERVICES

Student Information:

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:

Name: _____ **Title:** _____

Address: _____

Phone: _____ **Fax:** _____ **License #**: _____

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

Signature: _____ **Date**: _____

Disability Information:

Diagnosis: _____ **Date of Diagnosis:** _____

Severity: ____ Mild ____ Moderate ____ Severe

Diagnosis: _____ **Date of Diagnosis:** _____

Severity: ____ Mild ____ Moderate ____ Severe

Additional Diagnoses:

_____

_____

Date of your last clinical contact with student: _____

What is the frequency and duration of symptoms of the student's condition(s)?

____ Daily ____ 1-3 times/week ___ 1-3 times/month ____ 1-3 times/year

How did you arrive at this diagnosis (X-ray, lab work, interview with student, behavioral observations, testing, etc.)? Please list all that apply:

_____
_____
_____
_____

Current treatment and medication regimen (including treating clinicians, frequency of treatment, medications, and side effects):

_____
_____
_____
_____

Please describe the substantially limiting symptoms that impact this student's functional abilities in the academic environment (which includes but is not limited to the classroom, homework, testing, etc.):

_____
_____
_____
_____
_____
_____

Please describe the substantially limiting symptoms that impact this student's functional abilities in the campus living environment (which includes but is not limited to residential living, the dining hall, navigating campus, etc.):

_____
_____
_____
_____
_____
_____

Based on your clinical evaluation, what accommodations do you think this student will need to be an active member of the East Carolina University community while managing these symptoms?

_____
_____
_____
_____
_____
_____

Will you be seeing the student again for their disability? Yes ___ No ___

If yes, when is your next scheduled appointment? _____

Please provide any additional information that you feel will be useful in determining the nature and severity of the student's disability and any additional recommendations for other resources the student will benefit from as they navigate their disability.

_____
_____
_____
_____
_____
_____

Please see addendum pages (pg. 5 and 6) and complete if applicable.

ECU DISABILITY SUPPORT SERVICES

ADHD Verification

Only complete if applicable to the student. Please indicate which of the following symptoms have persisted to a degree that is maladaptive and inconsistent with developmental level.

Symptoms of Inattention	**Mild**	**Moderate**	**Severe**	**N/A**
Fails to give close attention to details or makes careless mistakes				
Has difficulty sustaining attention				
Does not appear to listen				
Struggles to follow through on instructions				
Has difficulty with organization				
Avoids or dislikes tasks requiring sustained				
Loses things				
Is easily distracted				
Is forgetful in daily activities				
Symptoms of Hyperactivity and Impulsivity				
Fidgets with hands or feet or squirms in a chair				
Has difficulty remaining seated				
Extreme restfulness; difficulty engaging in activities quietly				
Acts as if driven by a motor				
Talks excessively				
Blurts out answers before questions have been completed				
Difficulty in waiting or taking turns				
Interrupts or intrudes upon others				

ECU DISABILITY SUPPORT SERVICES

Allergy Verification

Only complete if applicable to the student. Please indicate which food groups may cause an allergic reaction including the severity, anaphylaxis reaction, and the type of contact.

Food Group:	Severity Level (Mild, Moderate, Severe):	Does this cause anaphylaxis?	Contact Type (Airborne, Touch, Ingestion):
Peanuts			
Tree Nuts			
Fish			
Shellfish			
Soy			
Dairy			
Eggs			
Wheat			
Other: _____			
Other: _____			