



UNIVERSITY of WISCONSIN
GREEN BAY

Student Accessibility Services

VERIFICATION OF DEAF/HARD OF HEARING

Student Accessibility Services provides services to students who are Deaf and hard of hearing. To determine eligibility for services, this office requires current comprehensive documentation of the hearing disability from the diagnosing audiologist, speech and hearing specialist or other professional.

Please Print Legibly

Student Name: _____

Date Completed: ____/____/____ Student's Date of Birth ____/____/____

1. Disability (HIM-10): _____

2. Date of diagnosis: ____/____/____

First contact with student ____/____/____ Last contact with student: ____/____/____

3. What is the severity of the disability? Please check one:

Mild

Moderate

Severe

Profound

Please include a copy of the most recent audiogram

4. Is the hearing loss expected to remain stable or is expected to decline? If it is expected to decline, describe the expected progression of the hearing loss.

5. Please describe your assessment procedures and evaluation instruments providing both quantitative and qualitative information about the student's abilities.

6. Please list and describe the major life activities/functional limitations, both physical and academic that are significantly impacted by the disability. Please indicate the degree of severity. **(Failure to identify to major life activities impacted by disability will result in no accommodations approved)**

7. What means of communication has the student used in the past? Also, describe the student's skill in the use of his/her communication skills.

8. What recommendations do you have regarding accommodations and/or auxiliary aids, i.e. notetaker, FM system, captioned videos, sign language interpreting, etc. in an academic setting? Also, state your rationale for the accommodations and/or auxiliary aids you have recommended.

9. Are there any other associated disabilities? Please describe.

Provider Information

Name:		Date:	
Medical Specialty:		License #:	
Address:			
Phone:		Email:	
Clinician's Signature:		Printed Name:	

Please mail or fax this completed form and any additional information to:

Student Accessibility Services
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