Disability Services Office

VERIFICATION OF DEAF/HARD OF HEARING

The Disability Services Office 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**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Specialty:</td>
<td>License #:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Email:</td>
</tr>
<tr>
<td>Clinician’s Signature:</td>
<td>Printed Name:</td>
</tr>
</tbody>
</table>

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

Disability Services Office        920-465-2841  
UW-Green Bay                        FAX 920-465-2191  
2420 Nicolet Drive, SS 1700          EMAIL: DIS@UWGB.EDU  
Green Bay, WI  54311