UNIVERSITY of WISCONSIN
GREEN BAY

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

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:

Disability Services Office
UW-Green Bay
2420 Nicolet Drive, SS 1700
Green Bay, WI 54311

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