Disability Services Office
VERIFICATION OF PHYSICAL/MOBILITY DISABILITY

The Disability Services Office provides services to students with diagnosed physical and/or mobility disabilities. To determine eligibility for services, this office requires current and comprehensive documentation of the medical condition from the diagnosing physician or health care professional currently treating the student.

Please Print Legibly

Student Name: ___________________________________________________________

Date Completed______/______/______  Student's Date of Birth______/______/______

1. Disability diagnosis: ___________________________________________________________

2. Date of diagnosis: _______/_____/______
   First contact with student______/______/______  Last contact with student:______/_____/______
   Is the student currently under your care? ___________________________________________

3. What is the severity of the disability? Please check one:
   ☐ Mild            ☐ Moderate            ☐ Severe
   Explain Severity:______________________________________________________________
   ______________________________________________________________

4. What is the expected duration of this disability? ________________________________
   ______________________________________________________________
5. Please list and describe the major life activities/functional limitations that are significantly impacted by the disability and degree of severity. *Please note if not major life activities are not significantly impacted, no accommodations may be considered.*


6. If the student is currently undergoing treatment, please describe and indicate how the treatment might affect the student academically. Please include any current medications and adverse side effects.


7. Describe any situation or environmental conditions that might lead to an exacerbation of the condition.


8. State specific recommendations regarding academic accommodations for this student, and the rationale as to why these accommodations/services are warranted based upon the student’s functional limitation. Indicate why the accommodations are necessary.


9. If any co-morbid conditions exist, 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