Disability Services Office

VERIFICATION OF SYSTEMIC HEALTH 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 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: _____/_____/_____

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

   Explain Severity: __________________________________________________________________________

4. Please describe the progression (if applicable) and 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 situations or environmental conditions that might lead to an exacerbation of the condition.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

8. State specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student’s functional limitations. Indicate why the accommodations are necessary (e.g. if a note taker is suggested, state reasons for this request related to the student’s diagnosis).

____________________________________________________________________________________

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

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Provider Information

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<th>Clinician’s Signature:</th>
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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

920-465-2841
FAX 920-465-2191
EMAIL: DIS@UWGB.EDU