

#### **DISABILITY VERIFICATION FORM**

The Office of Accessibility (**OA**) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act Amendments (ADAAA) of 2008. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activity. Eligibility for accommodations will be determined on a case-by-case basis following communication with the student and a thorough review of documentation indicating functional limitations that would impact the individual in an academic setting.

OA engages an interactive process including the student and self-report, history of effective accommodations, OA staff, and any supportive documentation. Relevant documentation will help define any functional limitations that may impact the student in the academic setting. The outline in this document has been developed to assist the student in working with the treating/diagnosing professional(s) in obtaining the specific and necessary information to evaluate requests for academic assistance based on the diagnosis.

**Please complete relevant information only.** Inadequate information and/or incomplete forms will delay the eligibility review process. All answers to the questions on the form must be legible. Illegible handwriting will delay the eligibility review process since the provider will need to be contacted for clarification. The professional(s) conducting the assessment and making the diagnosis must be qualified to do so. The professional should be trained, certified and/or a licensed psychologist, and/or member of a medical specialty group.

The provider should attach any reports which provide additional related information (e.g. psychoeducational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report providing the requested information is available, copies may be submitted for documentation in lieu of this form. Please include a narrative that discusses the results for all case notes or rating scales.

Important: OA will send an email notification to the student's Winthrop email account, (e.g. virest2@winthrop.edu), acknowledging receipt of documentation. Prospective students who do not have a Winthrop email account will be notified via alternate email, if provided.

Accessibility • Testing Program
307 Bancroft Hall • Rock Hill, South Carolina 29733
803/323-3290 • Fax 803/323-4585

(This Page is to be Completed by Student)

### STUDENT INFORMATION

(Please Print Legibly)

Name:	E'	) M' 1.11.
Last	First	Middle
Date of Birth:	CWID:	W
Student Status (check one): pro	ospective current trans	fer
Local phone: ()	Cell phone: (_	)
Address (street, city, state and zip	code):	
Winthrop E-Mail address:		@mailbox.winthrop.edu
Alternate E-mail address:		
Records Released From (ie Health	r Facility, Provider):	
Name:		_
Address:		
City:		Zip:
Phone:	Fax:	
✓ I hereby give permission for the relevant information for the purpo Winthrop University.	<u>-</u>	· •
Patient Rights:  I have had the opportunity to read this f questions regarding this Notice answered clearinghouses must follow the federal health information (PHI) does not fall in federal privacy standards therefore, all authorization. I understand that I may can that action has not already been taken, a written notification is required.	d to my satisfaction. I understand the privacy standards. If an individual not one of these categories, this autilowing for the possibility of my neel this authorization but that my was a standard to make the categories.	at only health care providers, plans, and or organization receiving my protected horization ceases to be protected by the PHI being redisclosed without further withdrawal is only effective to the extent
This authorization will remain in effect u effective for an additional time period. W		
I have had an opportunity to review and authorization, I am confirming that it acc		rization form. By signing this
Patient/Client/Student Signature		Date

(Remainder is to be Completed by <u>Appropriate Professional</u>. Please Complete Items as Applicable.)

**NOTE: FOR LEARNING DISABILITIES** – Please include a psycho-educational evaluation with intelligence and achievement testing (utilizing adult norms), administered by a psychiatrist or educational psychologist.

### **DIAGNOSTIC INFORMATION**

(Please Print Legibly)

. Diagnosis information:		-			
a) Disability:					
b) If mental or psychological, please					
c) Note the date of diagnosis, level of last page if additional space is need	-	ected o	luration fo	or each o	diagnosis (use
Diagnosis/Disability	Date of Diagnosis	Mild	Moderate	Severe	Expected duration
d) Date of initial contact:					
2. Is the student/patient currently under y 3. List current medications(s), impact, an	our care?	Yes	N		
4. If the student is currently undergoing treatment might affect the student acade		t, pleas	e describe	and inc	dicate how the

# 5. Major Life Activity Assessment

Please indicate what major life activity/ies is/are substantially limited and may result in specific functional limitations in a postsecondary academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, unable to walk more than 50 feet without fatigue, when active may incapacitate, etc.). Please provide any relevant comments.

raugue, when active may mca	Mild	Moderate	Severe
Bending			
Breathing			
Caring for Oneself			
Communicating			
Concentrating			
Eating			
Hearing			
Interacting with Others			
Learning			
Lifting			
Major Bodily Functions			
Memorizing			
Performing Manual Tasks			
Reaching			
Reading			
Seeing			
Sitting			
Sleeping			
Speaking			
Standing			
Thinking			
Walking			
Working			
Writing			
Other:			
Other:			

# Winthrop University Disability Verification Form

5.	there any situations or environmental conditions that might lead to an exacerbation of the lition?				
-					
6.	Please state specific recommended academic accommodations: (List specific accommodations):				
-					
6.	Based on your knowledge of the current status and history of the student's disability, how long do you advise that this student have access to each of the accommodations you recommended above (i.e. one academic semester, one academic year, academic life, etc.)?				
-					
7.	Please describe the impact and functional limitations of the condition relative to the classroom.				
8.	Please add any additional comments that you feel are appropriate.				
-					

Please attach any additional documentation that you believe to be relevant (e.g., psychological assessment, neuropsychological evaluation, diagnostic testing, etc.).

#### PROVIDER INFORMATION

(Please sign and complete fully)

Signature:	_Date:			
Print Name and Title:				
License or Certification #:				
Address:				
Telephone:				
To maintain confidentiality, all information should be sent to:				

Office of Accessibility Winthrop University 307 Bancroft Hall

307 Bancroft Hall Rock Hill, SC 29733 Fax: 803/323-4585 Phone: 803/323-3290

Email: accessibility@winthrop.edu