WINTHROP UNIVERSITY | *Office of Accessibility*

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. psycho-educational 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.*

I**mportant: 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.**

Student's Name _____ Student's DOB _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This page is to be completed by the Student; please print legibly.

Student Information

Name: _____
Last First Middle

Date of Birth:_____ CWID: W_____

Student Status (check one): _____ prospective _____ current _____ transfer

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 (i.e. Health Facility, Provider…)

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax: _____

✓ I hereby give permission for the above named provider/facility to release diagnostic and other relevant information for the purpose of determining eligibility for services/accommodations at Winthrop University.

Patient Rights

I have had the opportunity to read this facility's Notice of Privacy Practices (as indicated) and have had all of my questions regarding this Notice answered to my satisfaction. I understand that only health care providers, plans, and clearinghouses must follow the federal privacy standards. If an individual or organization receiving my protected health information (PHI) does not fall into one of these categories, this authorization ceases to be protected by the federal privacy standards therefore, allowing for the possibility of my PHI being redisclosed without further authorization. I understand that I may cancel this authorization but that my withdrawal is only effective to the extent that action has not already been taken, as a result of my signing this form. In order to withdraw this authorization written notification is required.

This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Student's Signature _____ Date _____

Student's Name _____ Student's DOB _____

DIAGNOSTIC INFORMATION

Remaining pages to be completed by the Appropriate Professional as applicable; please print legibly.

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.

1. Diagnosis information:

   a) Disability: _____

   b) If mental or psychological, please include DSM-V code(s): _____

   c) Note the date of diagnosis, level of severity and expected duration for each diagnosis (use last page if additional space is needed):

Diagnosis/Disability	Date of Diagnosis	Mild	Moderate	Severe	Expected duration

   d) Date of initial contact: _____

   e) Date of last contact: _____

2. Is the student/patient currently under your care? ___Yes ___No

3. List current medications(s), impact, and adverse side effects.

_____

_____

_____

4. If the student is currently undergoing treatment (i.e. medication, procedures, counseling, etc.) for the above condition(s) or otherwise, please describe and indicate how the treatment might affect the student academically.

_____

_____

_____

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**.**

	N/A	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:				

6. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_____

_____

_____

_____

7. Please state specific recommended academic accommodations: (List specific accommodations):

_____

_____

_____

_____

8. Based on your knowledge of the current status and history of the student's disability, how long do you believe this student will need each of the accommodations you recommended above?

_____

_____

_____

9. Please describe the impact and functional limitations of the condition relative to the classroom.

_____

_____

_____

_____

10. 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.).

Student's Name _____ Student's DOB _____

Provider Information- *Please complete fully and sign.*

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
G04 Bancroft Hall
Rock Hill, SC 29733

Email: **accessibility@winthrop.edu**

Fax: 803/323-4585
Phone: 803/323-3290