Augustana College
Disability & Access Resources
639 38th Street Rock Island, IL 61201
Disabilityservices@augustana.edu
Phone: (309) 794-8818 Fax: (309) 794-8942

Verification and Documentation of Disability

Student Authorization (to be completed by the student)

I Student Name _____ authorize Physician Name _____ to release information related to my diagnosis(es) and treatment to Augustana College Disability & Access Resources for the purposes of obtaining academic accommodations.

Clinic Address: _____

_____

Clinic Phone: _____ Clinic Fax: _____

Student Full Name: _____

Birthdate: ____/____/_____

Signature: _____ Date: _____

Please note: By signing or typing your name in the Signature field, you are officially signing this release form; any records obtained are the sole possession of Disability & Access Resources at Augustana College. These records are held confidentially by our office.

Verification of Disability (to be completed by provider)

Provider: The patient/client, listed above, has requested academic accommodations for their disability during their enrollment at Augustana College. To ensure the provision of reasonable and appropriate services, students needing accommodations are required to provide documentation verifying their disability and its functional impact. You may also provide an evaluation/diagnostic report instead of this document. Thank you for providing this information in a timely manner.

Medical Diagnosis(es)/DSM-IVR Diagnosis(es): _____

_____

Date of original diagnosis: ____/____/_____

Is the patient/client currently under your care: ☐ **Yes** ☐ **No**

When did you last see the patient/client: ____/____/_____

Is the disability temporary or permanent: _____

Is the permanent disability stable/unchanging or subject to fluctuation/progression:

_____

Please rate the impact of your client's disability on major life activities

Function	Minor	Moderate	Major	Comments/Symptoms
Caring for oneself	☐	☐	☐	
Performing manual tasks	☐	☐	☐	

Function	Minor	Moderate	Major	Comments/Symptoms
Walking	☐	☐	☐	
Sitting	☐	☐	☐	
Standing	☐	☐	☐	
Reaching	☐	☐	☐	
Lifting	☐	☐	☐	
Sleeping	☐	☐	☐	
Hearing	☐	☐	☐	
Seeing	☐	☐	☐	

Function	Minor	Moderate	Major	Comments/Symptoms
Interacting or communicating with others	☐	☐	☐	
Speaking	☐	☐	☐	
Breathing	☐	☐	☐	
Writing	☐	☐	☐	
Learning	☐	☐	☐	
Other	☐	☐	☐	

Describe the student's functional limitations in an educational setting:

Please list any accommodations/other pertinent information that would support the student within the College environment. *(e.g. extended time on tests, record class lectures)*:

Does this student continue to need the above services or accommodations when utilizing any necessary medications? ☐ **YES** ☐ **NO** ☐ **N/A**

Do any necessary medications have side effects that negatively impact the student's learning? ☐ **YES** ☐ **NO** ☐ **N/A**

If yes, please explain how the side effects impact the student's learning:

Please attach other information relevant to this student's academic accommodations, if needed.

By your signature, you attest that all information contained on this form regarding the aforementioned student/client is accurate to the best of your knowledge and that you hold the appropriate credentials to diagnose and verify this information.

Provider Name and Credentials (Print)**:** _____

Provider Signature: _____ Date: _____