

Office of Accessibility Resources

Disability Verification Form

Student Information (This section must be completed by the student)

| First: | Middle: | Last: |
|--------|---------|-------|
| | | |

| Student ID# | |
|---|----------------------------------|
| Local Address | |
| Permanent Address | |
| Cell Phone | |
| Ship. Email | |
| Status | (Current, Transfer, Prospective) |
| Semester you would like accommodations to begin | |

The remainder of this document must be completed by a certified/licensed Health Care Provider

Diagnostic Information

| Primary Diagnosis | |
|--|--------------------------|
| Secondary Diagnosis | |
| Date of Diagnosis | |
| Severity | (Mild, Moderate, Severe) |
| Medication or treatment that the student is currently prescribed | |

Major Life Activities Impacted

What major life activity/activities (including, but not limited to, seeing, hearing, walking, standing, thinking, learning, reading, concentrating, etc.) are impacted by the disability? Please indicate severity of impact and the limitations for the student:

Accommodations

Please state specific recommendations regarding academic accommodations for this student:

Additional Information

Please add any additional information that you feel is appropriate to support the student in their request for accommodations:

Healthcare Provider Information

Must be completed by Health Care Provider

| Provider Name | |
|---------------------------|--|
| Provider Title | |
| License or Certification# | |
| Address | |
| Phone number | |
| Fax number | |
| Email | |
| Provider Signature | |

Documentation for eligibility must reflect the current functional impact the disability has on the student's learning or other major life activity and the degree to which it affects the individual in the context (dining, learning, residential, etc.) for which the accommodation(s) is/are requested.

A connection must be established between the requested accommodation and the functional limitations on the student in the college environment (learning, residential, etc.).

Health Care Providers should send the completed Disability Verification Form to the Office of Accessibility Resources in one of the following ways:

Email: oar@ship.edu

Fax: 717-477-4094

Mail: Office of Accessibility Resources, Mowrey Hall 252

1871 Old Main Dr.

Shippensburg, PA 17257