UNIVERSITY OF SOUTHERN INDIANA®

Disability Resources

Verification of Disability Form to Request Academic Accommodations

Documentation must be submitted by a qualified practitioner who is not a family member of the student. Individualized Education Programs (IEP) or 504 Plans may assist in determination of services, but submission of those documents alone may not meet USI Disability Resources documentation guidelines. **If this accommodation request is for an Emotional Support Animal or Housing Accommodation, please print the appropriate form from our webpage: USI.edu/disability-resources.**

Student Information

Student Full Name: _____ Date of Birth: _____

Please provide all information requested in full. Comprehensive and detailed documentation is essential to help us thoroughly understand the student's needs and how they impact their learning. This vital information will help determine reasonable accommodations to effectively support the student. Please note that providing limited or vague answers may limit our ability to accurately assess and determine the appropriate level of support required.

Clearly state the student's diagnosed disability or condition. _____

_____

_____

_____

Is this diagnosis: ☐ Permanent ☐ Temporary **Expected Duration/Estimated End Date:** _____

Please indicate the appropriate frequency of symptoms:

☐ Several times per year ☐ Monthly ☐ Weekly ☐ Daily ☐ Other: _____

Does the impairment substantially limit one or more life activities? ☐ Yes ☐ No

Which major life activities are affected? ***(Check all that apply.)***

☐ Walking	☐ Reading	☐ Lifting	☐ Communicating	☐ Hearing	☐ Working
☐ Eating	☐ Bending	☐ Vision	☐ Learning	☐ Sleeping	☐ Self care
☐ Manual tasks	☐ Breathing	☐ Concentrating	☐ Standing	☐ Thinking	☐ Speaking
☐ Operation of major bodily functions		☐ Other:			

Please describe how each item checked above impact the student's functioning, specifically within a higher education environment.

_____

_____

_____

_____

Please list any current medications, treatments or assistive devices and their side effects that may impact the student in an academic setting. _____

_____

_____

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What, if anything, triggers symptoms or episodes? Please be specific: _____

_____

_____

Does the student have any current/ongoing medical restrictions as a result of their disability? If so, please describe.

_____

_____

_____

Certifying Professional: By signing below, I certify that I am a qualified professional in the field related to diagnosis and am not a family member of the student.

_____
Date

_____
Name (Printed) and Title

_____
Name of Practice

_____
Professional Credentials

_____
License or Certification No.

_____
Signature of Professional

_____
Telephone No.

RETURN TO:

USI Disability Resources, SC2206
8600 University Boulevard
Evansville, IN 47712

Phone: 812-464-1961 | **Confidential Fax:** 812-464-1935 | **Email:** usi1disres@usi.edu

USI.edu/disability-resources/documentation-guidelines

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