



Office of Disability and Access Services

Disability Verification Form

The student named below has asked to register with the Office of Disability and Access Services (ODAS) at Goodwin University. ODAS requires documentation of the student's disability in order to establish eligibility and provide services. Documentation must include a medical or clinical diagnosis of the disability based on ICD Codes and/or the DSM-5 and a rationale for the diagnosis.

This evaluation form must be completed by a licensed health professional.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. **To establish that an individual is covered under the law, documentation must indicate that a disability exists and that the disability substantially limits one or more major life activities. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and academic adjustments.**

The information you provide will not become a part of the student's educational records but will be kept in the student's file at ODAS where it will be kept confidential. Please contact Molly Zatony, Disability and Access Services Manager at mzatony@goodwin.edu or 860-727-6718 with any questions or concerns. Thank you for your assistance.

All documentation is considered confidential and can be sent to:

ATTN: Molly Zatony, Disability and Access Services
One Riverside Drive
East Hartford, CT 06118

Fax: 860-913-2196

Office of Disability and Access Services

Disability Verification Form

Student Name: _____

FOR THE CURRENT TREATING HEALTHCARE PROVIDER TO COMPLETE

Date of Diagnosis: _____

Date of your last clinical contact with student: _____

Please list all DSM-5 and/or ICD Diagnoses _____

Are there any coexisting conditions, including medical disabilities, emotional/psychological, or learning disabilities that should be considered when providing accommodations? _____

EVALUATION

How did you arrive at this diagnosis?

- | | | |
|--|---|---|
| <input type="checkbox"/> Structured or unstructured interviews with student | <input type="checkbox"/> Behavioral observations. | <input type="checkbox"/> Neuropsychological testing |
| <input type="checkbox"/> Interviews with other persons (i.e. parent, teacher, therapist) | <input type="checkbox"/> Developmental history | <input type="checkbox"/> Psychoeducational testing |
| | <input type="checkbox"/> Educational history | <input type="checkbox"/> Medical testing |
| | <input type="checkbox"/> Medical history | <input type="checkbox"/> Ratings scales |

Other (please specify) _____

FUNCTIONAL LIMITATIONS

Please check below the major college life activities that are affected to a substantial degree because of the disability:

- | | | |
|---|---|--|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Memory | <input type="checkbox"/> Managing deadlines |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Reading | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Learning | <input type="checkbox"/> Writing | <input type="checkbox"/> Classroom group functioning |
| <input type="checkbox"/> Organization | <input type="checkbox"/> Testing | <input type="checkbox"/> Social interactions |
| <input type="checkbox"/> Focus or concentrating | <input type="checkbox"/> Regular class attendance | |

Other (please specify) _____



Describe current symptoms that impact the individual's ability to perform in a college setting, including attendance:

What is the student's prognosis? How long do you anticipate the student's performance in a college setting will be impacted by the disability?

Past Accommodations: (K-12, prior institutions, CollegeBoard, etc.) Please describe if applicable:

Suggested Accommodations: Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis.

(Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

PROVIDER INFORMATION

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print name and title: _____

State of license: _____ License number: _____

Address: _____

City _____ State _____ ZIP code: _____

Phone: _____ Fax: _____