Cincinnati State
OFFICE OF DISABILITY SERVICES

Disability Verification Form

The Office of Disability Services (ODS) ensures that students with special needs receive the academic accommodations they need in their courses of study. Students with diagnosed disabilities, as defined under the Americans with Disabilities Act (ADA) of 1990 or the guidelines for section 504 of the Rehabilitation Act of 1973 may register with ODS.

Students are responsible for obtaining and providing disability documentation, including necessary testing/psychological evaluations at their own expense. It is important to realize that although the diagnostician may recommend specific accommodations, the determination for providing appropriate and reasonable accommodations and/or academic adjustments rests with the institution.

To help in this process, input from the student's healthcare professional is required to establish accommodations for the student.

The person completing this form should be a healthcare professional who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is part of the student's treatment plan for a previously diagnosed condition. These professionals are generally trained, certified, or licensed to diagnose and/or treat medical conditions. Examples include: a medical doctor, clinical psychologist, licensed clinical social worker, optometrist, audiologist or other qualified professional/organization.

Please complete all parts of the form as thoroughly and legibly as possible to avoid delay in service delivery to the student.

Please attach to this form any other documents or information you think would be relevant in determining the student's academic accommodations.

The information you provide will be kept in the student's Disability Services file, where it will be held securely and confidentially.

Completed forms may be faxed to ODS at 513-569-4744 or scanned and emailed (pdf file formats only) for processing. If you have questions regarding this form, please call 513-569-1775 or email disabilities@cincinnatistate.edu .

Thank you for your assistance.

To be completed by the STUDENT

(Please TYPE or PRINT LEGIBLY)

Are you currently enrolled at Cincinnati State? _____

Name: _____

Date of Birth: _____

Address: _____

City, State, ZIP Code _____

Phone Number: _____ Student ID Number (if applicable): _____

Email address: _____

Release of Information: For the purpose of establishing eligibility for accommodation and services, I give the healthcare professional completing this form permission to release my healthcare information to the Office of Disability Services at Cincinnati State Technical & Community College.

X_____ _____
Student Signature Date

X_____ _____
Parent Signature (if student is under age 18) Date

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Disability Verification Form

To be completed by certifying PROFESSIONAL

(Please TYPE or PRINT LEGIBLY)

Student's Name: _____

Student's Date of Birth: _____

Date of most recent evaluation: _____

Primary Diagnosis: _____

Date of Primary Diagnosis: _____

Other Diagnoses: _____

The diagnostic criteria or tests used:_____
_____
_____
_____
_____

Is the primary disorder: Stable___ Declining ___ Improving ___

Is the secondary disorder: Stable___ Declining ___ Improving ___

What treatments, medications, devices or services are currently prescribed or used to minimize the impact of the disorder(s)?
_____
_____
_____
_____

What is the expected duration of the disability?
_____
_____
_____
_____

Please describe how the student's disability symptoms or treatment plan impacts their academics:
_____
_____
_____
_____

Please state specific recommendations regarding academic accommodations for this student:
_____
_____
_____
_____
_____
_____

Please add any additional comments that you feel appropriate:
_____
_____
_____
_____

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Disability Verification Form

CERTIFYING HEALTHCARE PROFESSIONAL

(Please TYPE or PRINT LEGIBLY)

Please sign and date form after completing all required fields below.

Provider Name & Title _____

Type of Specialty or License: _____

Address _____

_____

Daytime Phone Number (_____)-(_____)-(_____)

Fax Number **(_____)-(_____)-(_____)**

X_____ _____ _____

Signature of Certifying Professional | License # / State | Date

The Office of Disability Services (ODS) will NOT accept documentation that is completed by, scanned, or faxed by a member of the student's family.

Please return this form via fax or email with any supporting documentation to:

Disability Services – Cincinnati State Technical & Community College

Clifton Campus
3520 Central Parkway
Main Bldg., Room 129
Cincinnati, Ohio 45223-2690
513-569-1775 (office)
513-569-4744 (fax)
disabilities@cincinnatistate.edu