

## 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.

To help in this process, input from a qualified healthcare professional with expertise in the area of the diagnosed disability is required to establish accommodations for the student.

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 college.

- **This form is to be completed by a licensed professional and/or properly credentialed healthcare professional** (e.g. medical doctor, clinical psychologist, licensed clinical social worker, optometrist, audiologist or other qualified professional/organization). ODS will NOT accept documentation that is completed by diagnosing/treating professionals related to the student requesting accommodations.
- 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 you think would be relevant in determining the student's academic accommodation needs**. This includes recent reports, test results, evaluations and assessments of the applicant's need for accommodations; and may include information regarding the history of the disability and past accommodations granted.
- Completed **forms must be faxed directly from the certifying healthcare professional to ODS** at 513-569-4744.

If you have questions regarding this form, please call 513-569-1775 or email [disabilities@cincinnatiastate.edu](mailto:disabilities@cincinnatiastate.edu).

Thank you for your assistance.

**To be completed by the STUDENT**

(Please TYPE or PRINT LEGIBLY)

Student Name: \_\_\_\_\_

Student Date of Birth: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Address: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Email Address: \_\_\_\_\_

Status (Check one):  Current Student  Prospective Student

CState Student ID Number (if applicable) \_\_\_\_\_

***I authorize the following individual or organization to release the requested information included in this document for the purpose of establishing eligibility for accommodations and services to the Office of Disability Services at Cincinnati State Technical & Community College.***

Name/Title: \_\_\_\_\_

Organization: (if applicable) \_\_\_\_\_

Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## DISABILITY VERIFICATION FORM

### To be completed by certifying Medical Practitioner/Specialist

(Please TYPE or PRINT LEGIBLY)

Student Name: \_\_\_\_\_

Student Date of Birth: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Date of most recent evaluation: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Other Diagnosis (if applicable): \_\_\_\_\_

How did you arrive at your diagnosis? If applicable, please attach the diagnostic reports and/or test results administered to determine the diagnosis.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 list any recommendations for accommodations you have for this student in an academic setting. Please note, recommendations will be considered in the interactive process; however, final decisions will be determined by the college.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## DISABILITY VERIFICATION FORM

Please add any additional comments that you feel would be useful in working with this student.

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### **Certifying Healthcare Provider Information**

(Please TYPE or PRINT LEGIBLY)

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

Provider Name (print): \_\_\_\_\_

Specialty Type or License: \_\_\_\_\_

License #/ State: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Daytime Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Fax Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Provider Signature: : \_\_\_\_\_ Date: \_\_\_\_\_

**Completed Disability Verification Forms (pages 1-4) along with any supporting documentation must be faxed directly from the certifying healthcare professional for processing 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@cincinnatiastate.edu