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.

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 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 e-mail disabilities@cincinnatistate.edu.

Thank you for your assistance.

Cincinnati State
OFFICE OF DISABILITY SERVICES

DISABILITY VERIFICATION FORM

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: _____

Cincinnati State
OFFICE OF DISABILITY SERVICES

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 & Date: _____

Other Diagnosis & Date (if applicable): _____

How did you arrive at your diagnosis? 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? (If temporary, specify length of time)

_____

_____

_____

Describe how the student's disability symptoms or treatment plan impacts their academics. Please focus on the student's unique experience rather than making diagnostic-related generalizations.

_____

_____

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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.

_____
_____
_____
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_____
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_____

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

_____
_____
_____
_____
_____

Cincinnati State
OFFICE OF DISABILITY SERVICES

DISABILITY VERIFICATION FORM

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 1-5) 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@cincinnatistate.edu