Cincinnati State
OFFICE OF DISABILITY SERVICES

DISABILITY VERIFICATION FORM

The Office of Disability Services (ODS) is responsible for providing reasonable and appropriate accommodations to students with diagnosed medical and mental health conditions. 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.

The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility. Note: This form serves as one option (not the only option) for providing disability documentation to ODS. Other examples include a diagnostic report or an IEP/504 plan.

Students are responsible for obtaining and providing disability documentation at their own expense. Although providers may recommend specific accommodations, the determination regarding appropriate and reasonable accommodations rests with the college.

- **This form is to be completed by a qualified healthcare professional with experience related to a disability diagnosis.** These professionals are trained, certified, or licensed to diagnose or treat the student's disability. For example, documentation from an Optometrist (eye specialist) denoting that a student has a mental health condition would not be accepted, but documentation of a visual impairment from an Optometrist may be considered. ODS will NOT accept documentation completed by diagnosing/treating professionals with a conflict of interest (including familial relations).

- **Please complete all parts of the form as thoroughly and legibly as possible**. Inadequate information, illegible handwriting, or missing fields may delay the eligibility review process. An editable PDF version of this form is available on our website. Typed answers are highly recommended.

- **Please attach to this form any other documents necessary to establish a diagnosis and determine 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. Please consider student privacy, and avoid providing documentation that speaks to the student's general medical history, including after visit summaries or progress notes.

- 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.

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To Be Completed by the STUDENT

(Please TYPE or PRINT LEGIBLY)

Student Name: _____

Student Date of Birth: _____

Address Line 1: _____

Address Line 2 (City, State, Zip Code): _____

Phone Number: _____ Email Address: _____

Status (Select 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.

Provider Name & Title: _____

Organization: (if applicable): _____

Phone Number: _____

Address Line 1: _____

Address Line 2 (City, State, Zip Code): _____

Student E-Signature: _____ Date: _____

I understand that adding my name to the Student E-Signature field above constitutes a legal signature. My Student e-Signature acts as a waiver of confidentiality, and verifies that I allow the Office of Disability Services to receive my disability documentation only from the provider named above to better assist me with registering for accommodations.

There is no requirement that I must waive this confidentiality, and sign the Student E-signature field above. My Student E-Signature above indicates I am aware there is no requirement to waive, and that I choose to waive that confidentiality to possibly be given the resources and benefits afforded by the Office of Disability Services.

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To Be Completed by Certifying Medical Practitioner/Specialist

(Please TYPE or PRINT LEGIBLY)

Student Name: _____ Student Date of Birth: _____

Date of most recent evaluation: _____

1. State the student's diagnosis(es) as per the most recent Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD). Please include the ICD code:

2. 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.

3. What is the expected duration of the disability? (select one) For students with multiple diagnoses, please indicate the applicable ICD code in the space provided.

   ☐ Temporary, ending _____: ICD Code(s) _____

   ☐ Indefinite (expected to last longer than 6 months): ICD Code(s) _____

   ☐ Indeterminate or Unknown: ICD Code(s) _____

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4. Select how the student's disability(ies) limit their ability to do the following major life activities:

	Able to do without accommodations	Able to do with reasonable accommodations	Unable to do with or without reasonable accommodations
Standing	○	○	○
Lifting	○	○	○
Writing	○	○	○
Grasping	○	○	○
Seeing	○	○	○
Hearing	○	○	○
Concentrating	○	○	○
Speaking	○	○	○
Processing Information	○	○	○
Reading	○	○	○
Attending Class	○	○	○
Other: _____	○	○	○

5. What treatments and/or medications are currently used to minimize the impact of the disability(ies)? When appropriate, please include side effects, treatment schedules, etc.

6. Please list recommendations you may have for this student's academic accommodations. Please consider the functional limitations you identified above. Note that while your recommendations are helpful in determining appropriate and reasonable accommodations, the final decision rests with the college.

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

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 Line 1: _____

Address Line 2 (City, State, Zip Code): _____

Daytime Phone Number: _____Fax Number: _____

Provider Signature: _____Date: _____

THIS FORM CANNOT BE SIGNED ELECTRONICALLY.
PLEASE PRINT, SIGN, AND RETURN TO THE FAX NUMBER LISTED BELOW

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-169
Cincinnati, Ohio 45223-2690

513-569-4744 (fax)
513-569-1775 (office)
disabilities@cincinnatistate.edu