

DISABILITY VERIFICATION FORM - ACADEMIC

Purpose of this Form

The University of Washington's Disability Resources for Students Office (DRS) approves academic, housing, and on-campus transportation accommodations. Your patient/client is requesting you to provide documentation of a disability for assessment of reasonable accommodations. Information provided on this form is protected by **FERPA**.

Instructions

- This form must be completed by a licensed healthcare professional credentialed to diagnose and treat the stated condition(s).
- The provider should clearly state the patient/client's diagnosis and how it impacts them. Failure to be thorough may result in denied accommodations.
- Must include signature & license information.

Guidance

- When students seek accommodations, the DRS needs to determine 1) if the student's physical or mental health condition qualifies as a disability, 2) the barriers and impacts the student experiences related to the disability, and 3) the level and severity of the impact(s).
- To view DRS's complete documentation guidelines, visit <http://depts.washington.edu/uwdrs/prospective-students/documentation-guidelines/>.

How to Submit

Students are responsible for the collection and submission of documentation to the University of Washington. This can be done by uploading it with their application to DRS or emailing their home campus.

- Seattle: uwdrs@uw.edu
- Bothell: uwbdrs@uw.edu
- Tacoma: drsugt@uw.edu

IMPORTANT: DRS will not accept, and will return, documentation that does not have the following information:

- Student name & ID number
- Healthcare provider signature & license information.

STUDENT INFORMATION (UW Student Completes This Section)		
Name		Phone
Student ID Number	UW Campus	Date of Birth

HEALTHCARE PROVIDER INFORMATION (Healthcare Provider Completes This Section)	
Name	
Address	
Phone	Email
Credentials and Licensing Information	

QUESTIONS (Healthcare Provider Completes This Section)
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1. What is the specific/working diagnosis(es), including the DSM-V or ICD code(s)?

2. Did they receive treatment for this condition prior to working with you? To your knowledge how long has your patient/client been receiving treatment?

3. When were the diagnoses made?

4. When was their initial appointment with you and are they still in treatment?

5. What is the highest level of impact on functioning (Select Only One)?

<input type="checkbox"/>	Level 0: Symptoms are temporary and expected/predicted responses to stressors. The impact on functioning is mild and intermittent (example: an individual may struggle to focus for several hours after an argument, but then concentration levels return to a manageable level).
<input type="checkbox"/>	Level 1: Symptoms are present more often than not. The impact on functioning is mild but consistent (example: some persistent difficulty concentrating may require additional coping strategies, but still able to complete work).
<input type="checkbox"/>	Level 2: The impact on functioning is moderate (example: difficulty concentrating means that work takes significantly longer to complete, and the student may meet some but not all deadlines).
<input type="checkbox"/>	Level 3: The impact on functioning is high (example: periods of high anxiety or disassociation resulting in persistent inability to maintain critical functions of being a student such as taking in information, completing assignments, attending class, etc.).
<input type="checkbox"/>	Level 4: The impact on functioning is severe (example: persistent inability to maintain minimal functions of living such as getting out of bed, hygiene, communicating with others, etc., resulting in inability to maintain minimal functions of being a student. Or they require full or partial hospitalization).

6. Describe how the patient/client's condition limits their functioning in the academic setting (Example: participation, reading, exams, attendance, assignments, note taking, mobility, etc.).

7. What physical or psychological situations/stimuli in the academic environment could trigger a flare-up? Describe the physical or psychological impacts, and the frequency and duration of the flare-ups.

8. Are there impacts from treatment interventions that affect the student's academic performance (Example: medication side effects, extensive time needed for interventions/hospitalization, etc.)? Please detail the specifics.

9. Does the student use any assistive mobility devices (Example: wheelchair, crutches, cane, etc.), personal care attendant, or service animal? If so, please list all applicable.

10. Does the student have a current need for adjustable furniture or facility modifications (Example: adjustable chair/desk).

Provider Signature:

Date: