Alfred University

Center for Academic Success (CAS)

Disability Verification Form for Students with Psychological, Sensory and Health-Related Disabilities

The Center for Academic Success provides support services for students with disabilities. CAS utilizes an interactive, case-by-case approach when determining eligibility for services and reasonable accommodations. Students requesting accommodations from CAS may be required to provide documentation regarding their specific disability. This documentation should demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (and the ADA As Amended in 2008). The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. For convenience, The Center for Academic Success provides the subsequent "Disability Verification Form" for medical, sensory, and mental health providers as a means for students with such diagnoses to provide documentation.

Appropriate documentation should include, but is not limited to, the following:

1. **Completed by a licensed professional and/or properly credentialed professional** (e.g. medical doctor, psychiatrist, psychologist, counselor, speech-language pathologist, etc.).
2. **All parts of the disability verification form should be completed as thoroughly as possible**. Where appropriate, summary and data from specific test results should be attached. If a comprehensive diagnostic report is available that provides the requested information it can be submitted in lieu of the disability verification form.
3. **The information provided on the disability verification form is maintained by CAS according to the guidelines of the Family Education Rights and Privacy Act (FERPA) of 1974**. This information may be released to the student upon their written request.

Please contact The Center for Academic Success at (607) 871-2148 with questions. Thank you for your assistance.

STUDENT INFORMATION
(to be completed by student)

First Name: ______________________________ Last Name: ________________________________

Status (Check one) ☐ Current Student ☐ Transfer Student ☐ Prospective Student

Phone: (_____) ______ - ________ Email: ____________________________________

I authorize the following individual or organization to release the information included in this document to Alfred University's Center for Academic Success:

Name: ____ Phone: (_____) ______ - ________

Email: ____

Address: _________________________________ City: __________________ State: _____ Zip: ______

Student Signature: ____ Date: ______________

DIAGNOSTIC INFORMATION
(to be completed by medical practitioner/specialist)

1. Please specify the specific diagnosis(es)/disability.

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If applicable, please rate the level of severity of the student's diagnosis?

Mild ☐ Moderate ☐ Severe ☐

Duration of condition: ☐ Permanent ☐ Temporary (specify length of time) _______________

Date of Diagnosis: ____________________ Date of last contact with student:_____________________

2. How did you arrive at your diagnosis? Please check all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

☐ Behavioral Observations/Development History

☐ Medical History

☐ Rating Scales (e.g., CAARS, Brown ADD Scales for Adults)

☐ Other (please specify): ____________________

☐ Neuro-Psychological Testing, Date(s) of Testing ______________________________

☐ Psycho-Educational Testing, Date(s) of Testing ______________________________

☐ Structured/unstructured student interviews

3. Please indicate the level of impact the student's disability may have in limiting the following major life activities:

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	Don't Know
Attending class regularly					
Caring for oneself					
Communicating					
Concentrating					
Hearing					
Interacting with others					
Learning					
Making/keeping appointments					
Managing external distractions					
Managing internal distractions					
Managing stress					
Meeting deadlines					
Memorizing					
Organization					
Performing manual tasks					
Reading					
Seeing					
Sleeping					
Thinking					
Writing					
Other:					

4. For the major life activities checked to have a moderate or substantial impact, please provide an explanation of the functional impact of the limitation in an academic setting.

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5. If applicable, please describe the relevant history of remediation (e.g. current medications, side effects of medications, other treatment plans and their effectiveness).

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6. Please list any recommendations for accommodations you have for this student in an academic setting and a brief rationale for your recommendation. (Please note, recommendations will be considered in the interactive process, however final decisions will be determined by CAS staff.)

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7. Please provide any additional information that you think would be useful to know in working with this student.

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HEALTHCARE PROVIDER INFORMATION

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): ____________________

Provider Signature: ____________________ Date: ____________

Title: ____________________

License or Certification #____________ National Provider Identifier (NPI): ____________

Address: ____________________

City: ____________________ State: __________ Zip: ____________

Phone: (______) ________ - ________ Fax: (______) ________ - ________

Please mail or email this completed form to:

Center for Academic Success · Alfred University · 1 Saxon Drive · Alfred, NY 14802
Phone: 607-871-2148
Email: CAS@alfred.edu · Web: my.alfred.edu/center-academic-success/