University of Virginia
Student Disability Access Center
PO Box 800760
Charlottesville, VA 22908-0760
Phone: 434-243-5180
Fax: 434-243-5188

VERIFICATION OF DISABILITY

Student Name _____ Date_____

Date of Birth:_____

The student named above has applied for services from the Student Disability Access Center (SDAC) at the University of Virginia. In order to determine eligibility and to provide services, we require documentation of the student's disability. Under the Americans with Disabilities Act (ADA) of 1990, as amended by the ADA Amendments Act of 2008, and Section 504 of the Rehabilitation Act of 1973, qualified individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations (which includes academic adjustments and auxiliary aids and services) necessary to ensure equal access to the University's programs and activities. To establish that an individual has a disability under the law, documentation must indicate that a current mental or physical impairment exists and that the identified impairment substantially limits one or more major life activities. A diagnosis of a disorder, or the existence of an Individualized Education Plan or Section 504 Plan, in and of itself, does not automatically qualify an individual for accommodations. The documentation must also address current functional limitations on the individual and support the request for accommodations. Documentation must be provided by a clinician or treating provider who is licensed and qualified to diagnose the condition and who is not a member of the student's immediate family. Should documentation be provided that SDAC finds to be inadequate to support the requested accommodations, SDAC will let the student know what additional documentation is necessary.

1. Diagnosis/Description of condition.

2. In addition to ICD-10 and/or DSM-5 criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student.

- ☐ Structured or unstructured interview with student
- ☐ Interviews with other persons
- ☐ Behavioral observations
- ☐ Developmental history
- ☐ Educational history
- ☐ Medical history
- ☐ Neuro-psychological testing (date of testing_____)
- ☐ Psycho-educational testing (date of testing_____)
- ☐ Standardized or non-standardized rating scales
- ☐ Other (please specify):

3. Symptoms/Manifestations of condition:

4. Date the diagnosis was formally established: _____

5. Date that the student was last seen: _____

6. Based on your subjective opinion, how well do you know this student?
   - ☐ Very Well
   - ☐ Moderately Well
   - ☐ Not Well At All

7. Expected duration of condition:
   - ☐ Permanent/Chronic
   - ☐ Short-term (60-90 days)
   - ☐ Long-term (3-12 months)
   - ☐ Temporary (60 days or less)

8. Current Treatment(s)/Therapy and Prescribed Medications and Dosage:

9. Does this individual's condition substantially limit one or more major life activities?
   - ☐ YES
   - ☐ NO

   If yes, list the specific activity or activities.

10. Please list any accommodations you recommend:

11. Optional: You may use the space below (and additional sheets as needed) to provide any other information that you believe will be helpful to University staff in considering the accommodations that you are recommending.

I, the undersigned, certify that the information provided for the aforementioned student is true and correct to the best of my knowledge and belief:

Treating Provider Signature (*if in training, please include supervisor signature*) Date

Name (*please print*)

Title / Name of Agency

Phone Number

Street Address

City / State/ Zip

All documentation submitted for consideration to SDAC is confidential. **Please include any available releases the student has signed** authorizing communication between the SDAC and the clinician or treating provider who is submitting this verification and any supporting documentation.