

Disability Verification Form

Students who are requesting accommodations from the Student Disability Services (SDS) office at Central Michigan University (CMU) are required to provide current (within three years) and comprehensive documentation of their disability. Federal law defines a disability as a "physical or mental impairment that substantially limits one or more major life activities." A major life activity is defined as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself.

Students who wish to receive academic accommodations must have this form filled out by a certified professional who has first hand knowledge of the student's condition.

Student Information

Date of Birth _____

(Please Print)

Last Name _____ First _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ CMU ID # _____

Campus Address _____ Campus Phone # _____

RELEASE OF INFORMATION

I, _____, hereby authorize the exchange and release of the following confidential information to Student Disability Services and Central Michigan University for the purpose of determining my eligibility for educational accommodations.

DATE

STUDENT'S SIGNATURE

CERTIFIED PROFESSIONAL

Please check the appropriate boxes, and provide supporting documentation (rating scales, clinical observation, past evaluations, etc) that clearly states how diagnosis functionally impacts the student's life, and return by fax or mail to address on reverse side of this form.

Diagnosis/Code _____ **Date of Diagnosis** _____

SELECT ANY PHYSICAL OR MENTAL IMPAIRMENT IMPACTED

PHYSIOLOGICAL DISORDER, CONTAGIOUS DISEASE, COSMETIC DISFIGUREMENT, ONE OR MORE SYSTEM:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Digestive | <input type="checkbox"/> Genito-urinary | <input type="checkbox"/> Hemic |
| <input type="checkbox"/> Lymphatic | <input type="checkbox"/> Skin | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Substance abuse* | | |

*Does not include current, illegal drug users

(over)

MENTAL OR PSYCHOLOGICAL DISORDER INCLUDING:

- ADHD/ADD
- Emotional or mental illness
- Organic brain syndrome
- Specific learning disability
- Traumatic Brain Injury
- Other _____

Major Life Activities

SELECT THE MAJOR LIFE ACTIVITIES THAT ARE IMPACTED BY THE DISABILITY:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Self-care | <input type="checkbox"/> Manual tasks | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speaking |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Thinking | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Learning |
| <input type="checkbox"/> Reproducing | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Working |

What recommendations would you suggest for accommodations based on the results of your evaluation?
The Student Disability Services office will make final determination as mandated by law.

- | | |
|---|---|
| <input type="checkbox"/> Accessible Transportation | <input type="checkbox"/> Sign Language Interpreter |
| <input type="checkbox"/> Extended Test Time (time and a half) | <input type="checkbox"/> TDD |
| <input type="checkbox"/> Notetaker | <input type="checkbox"/> Wheelchair Accommodating Housing |
| <input type="checkbox"/> Quiet Area for Test | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Reader for Tests | <input type="checkbox"/> Other _____ |

Certifying Professional

(Please Print)

Name and Title _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ Fax _____

Date of Initial Contact With Student _____ Date of Last Contact With Student _____

LICENSE/CERTIFICATION # AND STATE OF LICENSER _____

I certify this student is disabled _____

CERTIFYING PROFESSIONAL'S SIGNATURE

Today's Date: _____

All documentation is confidential.

If you have questions regarding the nature of the information needed for students with disabilities, please call Student Disability Services at 989-774-3018 Monday through Friday from 8:00 a.m. to 5:00 p.m.

This form should be returned to:
Student Disability Services
120 Park Library
Central Michigan University
Mt. Pleasant, MI 48859
Fax: 989-774-1326