**VERIFICATION OF DISABILITY FORM**

Student Name: _____ Birthdate: _____

I am requesting disability support services through the Student Disability Services (SDS) at the University of Nebraska Medical Center. The SDS requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability-related accommodations or services. Please respond to the following questions as soon as possible, and return to me or send to SDS by mail or fax. I authorize the Student Disability Services Office to contact you if clarification is needed.

Student Signature: _____ Date: _____

Health care provider name (print): _____

Title: _____ Phone: _____ Fax: _____

Organization and address:

_____

*The following area must be completed by the health care professional listed on this page.*

1. Diagnosis(es) and date(s):

   _____

   _____

2. Current status of condition(s) (e.g., active, progressing, controlled, in remission):

   _____

3. Current level of severity (choose one): Mild Moderate Severe

4. How long is this condition(s) likely to persist (be as specific as possible – e.g., lifetime; 1 academic year; duration of academic program enrollment; 1 month):

   _____

5. Please list procedures/assessments used to diagnose this student's condition:

   _____

   _____

   _____

   _____

   _____

6. What are the functional limitations or symptoms of this condition(s)?

_____
_____
_____
_____

7. What exacerbates this student's specific disability (ies)? (Please be as specific and detailed as possible)

_____
_____
_____
_____

8. How does the condition (and /or current treatment) impact the student's ability to learn or meet the demands of the university setting, clinical requirements, and /or the ability to live in university housing?

_____
_____
_____
_____

9. Identify any accommodations you believe may be necessary in order for the student to participate in the university's programs, activities, and services:

_____
_____
_____
_____

**This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider.**

Signature of Treatment Provider _____

License # _____

Date _____

Thank you for your cooperation. You may fax or email your report to the UNMC Student Disability Services Office at 402-559-9671, or Kelly.Swoboda@unmc.edu. Please call 402-559-7276 if you require additional information. Please attach any additional reports or relevant information. All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).