Office of Student Life
Disability Services

Warner Center 226
1179 University Drive
Newark, Ohio 43055

740.366.9441 Phone
740.364.9646 Fax

www.newark.osu.edu/studentlife/ODS/

Disability Verification Form

The Office for Disability Services (ODS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (psychiatrist, psychologist, counselor, therapist, social worker, medical doctor, optometrists, speech-language pathologists etc.) in obtaining the specific information to evaluate eligibility for academic accommodations.

A. The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained, certified, or licensed to diagnosis medical conditions.

B. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. ***It is recommended that this form be completed by typing the information into the editable PDF version of the form available on our website (www.newark.osu.edu/studentlife/ODS/).***

C. The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.

D. The information you provide will be kept in the student's file at ODS, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

If you have questions regarding this form, please call the ODS office at 740.366.9441. Thank you for your assistance.

STUDENT INFORMATION

(Please Type or Print Legibly)

First Name: _____ **Middle:** _____ **Last:** _____

Date of Birth: _____ **Last 4 digits of SSN:** _____

Status (check one): ◯ **current student** ◯ **transfer student** ◯ **prospective student**

Local phone: (_____) - _____ - _____ **Cell phone: (_____) - _____ - _____**

Address:

Street _____

City, State, Zip _____

If Ohio State student, OSU E-mail:

_____@ ◯ **buckeyemail.osu.edu OR** ◯ **osu.edu**

Non-student E-mail address: _____

Important: After documentation is reviewed, ODS will send email notification to the student's Ohio State email account, (e.g. name.123), acknowledging receipt of documentation and eligibility status.

DIAGNOSTIC INFORMATION

(Please Type or Print Legibly)

1. Date of Diagnosis: _____

2. Primary Diagnosis: _____

   Secondary Diagnosis: _____

3. What is the severity of the disorder? ◯ **Mild** ◯ **Moderate** ◯ **Severe**

4. Please state the medication or treatment the student is currently prescribed:

5. Major Life Activities Assessment: *Please check which of the following major life activities listed below are affected because of the impairment. Indicate severity of limitations.*

Life Activity	Negligible	Moderate	Substantial	Don't Know
Concentrating	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Regular Class Attendance	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Communicating	☐	☐	☐	☐
Keeping appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Organization	☐	☐	☐	☐

6. In addition to the major life activities affected that are indicated above, please describe any activities that may be impacted by the disability or symptoms that may need to be addressed in the college environment:

7. Please state specific recommendations regarding academic accommodations for this student:

8. Please add any additional comments that you feel are appropriate:

HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and completely fill in all other fields using TYPE or PRINT)

Provider Signature: _____ **Date**: _____

Provider Name (Print): _____

Title: _____

License or Certification #: _____

Address:

Street _____

City, State, Zip _____

Phone Number: (_____) - _____ - _____

FAX Number: (_____) - _____ - _____