NORTH SEATTLE COLLEGE
One of the Seattle Colleges

Disability Services
College Center Bldg, 2nd Floor
9600 College Way North
Seattle, Washington 98103-3599
(206) 934-3697

DISABILITY VERIFICATION FOR STUDENTS

(To Be Completed By Qualified Health Care Professional)

To determine appropriate accommodations, North Seattle College must have verification of a disability and the resulting functional limitations. Information on this form will be used in confidence for the **academic benefit** of the student. Inadequate information, incomplete answers, or illegible handwriting may delay the process. **Please attach additional documents that may be relevant in determining the student's eligibility for accommodations.**

STUDENT INFORMATION **(NSC Student Completes This Section)**		
Name:		Phone:
Student ID Number:	Date of Birth:	
HEALTHCARE PROVIDER INFORMATION **(Healthcare Professional Completes This Section)**		
Name:	Credentials and Licensing Information:	
Address:		
Phone:	Fax:	Email:
DISABILITY ASSESSMENT **(Healthcare Professional Completes This Section)**		
1. Please state DSM-V or ICD-10 Diagnosis(es):		
2. The above diagnosis(es) is: __ permanent/chronic OR __temporary until ________		

3. Level of Severity:	4. Date of Diagnosis(es):	5. Date of Last Contact with Student:

DISABILITY ASSESSMENT (CONT.)
(Healthcare Professional Completes This Section)

6. What tools are methods were used to evaluate the student's symptoms and make the diagnosis(es)?

7. Please describe the current symptoms of the stated diagnosis(es) this student experiences:

8. If the student experiences episodic flare-ups due to their condition, please describe any triggers, the frequency and duration of episodes, and the types of service (e.g, individual therapy, medication, etc.) for management and recovery of flare-up episodes.

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9. Please describe the functional limitations and severity of impact on the student in the academic setting. Please note that accommodations will be determined based on documented, specific functional limitations.

DISABILITY ASSESSMENT (CONT.)

(Healthcare Professional Completes This Section)

10. Describe medications prescribed to the student and any side effects/functional limitations resulting from treatments or medications.

By signing below I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Signature: ____ Date:______________________

Please return this form to the student, or submit via email to DS@seattlecolleges.edu , or fax to 206 934-3958. For questions, contact DS@seattlecolleges.edu or 206-934-3697.

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