Disability Services
College Center Bldg, 2nd Floor
9600 College Way North
Seattle, Washington 98103-3599
Phone: 206-934-3697
Fax: 206-934-3958
ds@seattlecolleges.edu

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 (to be completed by student):

Name:

Student ID Number:

Date of Birth:

Phone:

Provider Information (to be completed by Healthcare Professional)

Name:

Credentials and Licensing Information:

Address:

Phone:

Fax:

Email:

Disability Assessment (to be completed by Healthcare Professional):

1.Please state DSM-V or ICD-10 Diagnosis(es):

2. The above diagnosis(es) is:

Permanent/Chronic ☐

Temporary until: ☐

3. Level of severity:

4. Date of diagnosis(es) (MM/DD/YYYY):

5. Date of last contact with student (MM/DD/YYYY):

6. What tools or 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 has episodic flare-ups due ot 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.

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

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

Signature (to be completed by Healthcare Professional)

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.

Provider 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.