OHIO CHRISTIAN
UNIVERSITY

Verification of Disability

Student Name: _____
Social Security Number:_____
Today's Date: _____ Date Needed:

The above student is requesting an auxiliary aid or service, reasonable academic adjustment, and/or other reasonable accommodation from Ohio Christian University (OCU) due to a disability. In order to ensure the provision of appropriate auxiliary aids and services, reasonable academic adjustments, or other reasonable accommodations, OCU has requested that a qualified healthcare professional provide current and comprehensive verification of the disability. The professional(s) conducting the assessment and rendering the diagnosis must be qualified to do so. A qualified healthcare professional includes a licensed school psychologist, licensed psychologist, licensed rehabilitation counselor, speech and language pathologist, physician, or other appropriate medical/healthcare professional.

The documentation and information requested by OCU should be comprehensive enough to identify the student's current functional limitations. It should also include information that diagnoses the impairment, indicates the longevity of the impairment, and the qualified professional completing this form may offer suggestions or recommendations for necessary and appropriate auxiliary aids or services, reasonable and appropriate academic adjustments, or other reasonable accommodations.

To facilitate the gathering of such critical information, please complete this form, attach to the diagnostic report, and return to:

Ohio Christian University
Attn: David Pennington
1476 Lancaster Pike
Circleville, OH 43113
Phone Number: 740-420-5906
Fax Number: 886-510-2708
complianceofficer@ohiochristian.edu

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If you have questions regarding this form, please contact:

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Circleville, OH 43113
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Fax Number: 886-510-2708
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1. Current diagnosis (include DSM diagnosis code, if applicable):_____

_____

2. Date of current diagnosis: _____

3. Expected duration of impairment or disability _____

4. Is this student/patient currently under your care? _____ Yes _____ No

5. Please describe the student's current functional limitations and/or how a major life activity is impacted so that OCU can determine appropriate auxiliary aids and services and academic adjustments to accommodate the student:

_____

_____

6. Optional. What suggestions or recommendations do you have regarding necessary and appropriate auxiliary aids or services, academic adjustments, or other accommodations for this student?

_____

_____

7. Please attach any psycho-educational testing and/or reports which provide current information related to the student/patient's disability or impairment, or describe any other information relevant to this student's request for academic adjustment, auxiliary aides or services, or other accommodation (e.g., effect of prescribed medications, exacerbating factors, etc.).

Healthcare Professional's Signature:_____**Date:**_____

Printed Name and Title: _____

Daytime Phone Number: _____**Fax:** _____

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Optional Limited Waiver for Student's Treating Healthcare Professional

To: _____(insert name of Student's treating healthcare professional)

The Student's signature below indicates that the Student has elected to provide to Ohio Christian University a limited waiver which shall permit Ohio Christian University officials to consult with you, only as necessary to better determine appropriate auxiliary aids and services and academic adjustments. This wavier is effective for one calendar year from the date indicated below.

Student Signature: _____ Date: _____