WINGATE 1896

Disability Support Services

Disability Verification Form

The Disability Support Office (DSS) provides academic services and accommodations for students diagnosed with 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 America with Disabilities Act Amendments (ADAAA) of 2008. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activity. Eligibility for accommodations will be determined on a case-by-case basis following communication with the student and through a review of documentation indication functional limitation that would impact the individual in an academic setting.

The outline in this document has been created to assist the student in working with the treating/diagnosing professional(s) in obtaining the specific and necessary information to evaluate request for accommodations based on diagnosis.

This form is not required to receive accommodations.

The professional(s) conducting the assessment and making the diagnosis must be qualified to do so. The professional should be trained, certified and/or a licensed psychologist, and/or member of a medical specialty group.

The provider should attach any reports which provide additional related information (i.e. psycho-educational testing, neuropsychological test results, etc.). *If a comprehensive diagnostic report providing the request information is available, copies may be submitted for documentation in lieu of this form. Please include a narrative that discusses the results for all case notes or rating scales.*

Student's Name:_____Student's DOB:_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This page is to be completed by the student; please print legible.

Student Information

Name:_____

Date of Birth:_____ Wingate Student ID:_____

Student Status (check one): ☐ Grad ☐ Current ☐ Transfer ☐ Incoming

Cell Phone:_____Wingate Email:_____@wingate.edu

Alternative email address:_____

Address: (street, city, state, and Zip code):

_____

_____

Records released from (i.e. Health Facility, Provider….A)

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Phone:_____Fax:_____

✓ I hereby give permission for the above-named provider/facility to release diagnostic and other relevant information for the purpose of determining eligibility for service/accommodations at Wingate University

✓ This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional period. Written consent is necessary to revoke request.

✓ I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Student's Signature:_____Date:_____

Student's Name:_____ Student's DOB:_____

DIAGNOSTIC INFORMATION

Remaining pages to be completed by the Appropriate Professional as applicable; please print legibly.

1. Diagnosis Information:

Diagnosis/Disability	Date of Diagnosis	Mild	Moderate	Severe	Expected duration
		○	○	○	
		○	○	○	
		○	○	○	
		○	○	○	

   a. Date of initial contact:_____
   b. Date of last contact:_____

2. Is the student currently under care? ☐ Yes ☐ No
3. Diagnostic Criteria/Test administered?

4. List current medication(s), impact, and adverse side effects.

5. If the student is currently undergoing treatment (i.e. medication, procedure, counseling, etc.) for the above condition(s) or otherwise, please describe and indicate how the treatment might affect the student academically.

6. **Major Life Activity Assessment** Please indicate what major life activity(ies) is/are substantially limited and may result in specific functional limitations in a postsecondary academic setting (i.e. problems sitting for long periods of time, unable to type for more than 10 mins, unable to walk more than 50 feet, etc.). Please provide any relevant comments.

Student's Name:_____ Student's DOB:_____

For Academic Accommodations

7. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

8. Please state specific recommended academic accommodations.

9. Based on your knowledge of the current status and history of the student's disability, how long do you believe this student will need each of the accommodations you recommend above?

10. Please describe the impact and functional limitations of the condition relative to the classroom.

Student's Name:_____ Student's DOB:_____

For Housing Accommodations (Single room or Assistance Animal)

7. Describe the current impact of the condition: (Including negative health impact that may be permanent or life-threatening if the request is not granted).

8. If this request is for a single housing request, how does sharing a room impact the student's ability to live and equally participate at Wingate University? Having an ESA is by itself not a reason to request a single room.

9. Would typical roommate adjustments (using headphones, a sleeping mask, sound machine, negotiating shared space, creating a roommate agreement) resolve the concern or hinder access to the space? Please explain.

10. Do you have alternative recommendations?

Student's Name:_____ Student's DOB:_____

11. Please add any additional comments that you feel are appropriate.

Please attach any additional documentation that you believe to be relevant (e.g. psychological assessment, neuropsychological evaluation, diagnostic testing, etc.).

Provider Information- *Please complete fully and sign.*

Signature:_____ Date:_____

Print Name & Title:_____

License or Certification #:_____

Address:_____

Telephone:_____

All information can be sent to:

Wingate University
Disability Support Services
P.O. Box 159
Wingate, NC 28174

Fax: 704-233-8268

Email: access@wingate.edu