DISABILITY/HEALTH VERIFICATION FORM

Access Center
Washington State University Vancouver
Vancouver, WA 98665-9600
Ph: 360.546.9739
Fax: 360.546.9421
van.access.center@wsu.edu

To ensure the provision of reasonable and appropriate accommodations for WSU Vancouver students, please provide current and comprehensive documentation of their disability and its impact on major life activities, including their educational environment.

We ask that you complete the following form and return it to the address above. All material will be kept confidential.

Thank you for your assistance in this matter.

Student's Name: Click or tap here to enter text. WSU ID #: Click or tap here to enter text.

This section of the form is to be completed by the health professional.

1. Name/Type of Disability/Chronic Health or Mental Health Condition (diagnosis):

   Click or tap here to enter text.

2. Please choose one: ☐ Temporary ☐ Chronic

   If temporary, estimated time of recovery period: Click or tap here to enter text.

3. Indicate any health or disability-related symptoms that affect major life activities that may impact the student in the academic or campus environment.

☐ Attendance
☐ Bending
☐ Communicating
☐ Controlling bodily functions
☐ Easily distracted
☐ Executive Functioning (time management, organization, planning)
☐ Inability to reduce stress
☐ Interacting with others
☐ Lifting
☐ Reading
☐ Screening out environmental stimuli
☐ Sitting
☐ Slower response to time-limited tests
☐ Walking
☐ Breathing
☐ Concentration/focus
☐ Eating/allergies
☐ Hearing
☐ Learning
☐ Slow processing speed
☐ Maintaining stamina
☐ Performing manual tasks
☐ Reading
☐ Memory/recall
☐ Seeing
☐ Sleeping
☐ Standing
☐ Typing
☐ Writing
☐ Other

Additional symptom information (optional): Click or tap here to enter text.

4. If this student currently on medication(s), describe any side effects this student experiences from medication(s). Please include time of day this is most likely to occur.

   Click or tap here to enter text.

5. Based upon your professional assessment, the student's clinical and academic history, and diagnosis, please provide any recommendations for accommodations that you believe will help remove barriers to the student's education at Washington State University Vancouver.

   Click or tap here to enter text.

I certify, by my signature below, that I am a trained health provider or mental health professional with training in the evaluation or treatment of chronic or mental health conditions.

Signature: _____ Date: _____

Print Name and Title: _____

Area of Specialty: _____

State License: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____

To be completed by WSU student:

I authorize the certified information in this form to be released to WSU Access Services. I consent to be contacted by WSU Access Services regarding this form.

Printed Name _____

Signature _____ Date _____