



Accessibility Services · Kilcawley Center Room 2082 · One University Plaza · Youngstown, OH 44555
Phone: 330-941-1372 · Fax: 330-941-7470
Email: cspds5@ysu.edu · Web: www.ysu.edu/disability

Accessibility Services (AS) provides support services for students with diagnosed disabilities. AS utilizes an interactive, case-by-case approach when determining eligibility for services and reasonable accommodations. Students requesting accommodations from AS may be required to provide documentation regarding their specific disability. This documentation should demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (and the ADA As Amended in 2008). The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

When filling out this form, please keep these things in mind:

1. It should be completed by a licensed professional and/or properly credentialed professional (e.g. medical doctor, psychiatrist, psychologist, counselor, speech-language pathologist, etc.). AS does not accept documentation completed by diagnosing /treating professionals related to the student requesting accommodations.
2. **All parts of the disability verification form should be completed as thoroughly as possible.** Where appropriate, summary and data from specific test results should be attached. If a comprehensive diagnostic report is available that provides the requested information it can be submitted in lieu of the disability verification form.
3. A learning disability assessment should include (a) a measure of cognitive aptitude and (b) a measure of achievement in reading, math and/or written language. Data should be based on age norms and reported as standard scores and percentiles.
4. **Printing or typing** on the form is preferred. If a form is illegible, it may be returned or you may be contacted for clarification.

If you have any questions, please call the Accessibility Services Office at 330-941-1372.

STUDENT INFORMATION

(to be completed by student)

First Name: _____ Last Name: _____

Phone: (_____) _____ - _____ YSU Email: _____

ID# Number Y00 _____

I authorize the following individual or organization to release the information included in this document to Accessibility Services at Youngstown State University: (Write in Qualified Professional's information)

Name/Title: _____ Phone: (_____) _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of establishing eligibility for accommodations and services, I give the mental health or health care professional permission to release my medical information to Accessibility Services at Youngstown State University.

Student Signature: _____ Date: _____

DIAGNOSTIC INFORMATION

(to be completed by medical practitioner/specialist)

1. Please specify the specific diagnosis(es)/disability. For psychological disabilities, please indicate both the name of the diagnosis, and the diagnostic taxonomy that was used.

Diagnostic taxonomy used: DSM 5 # _____ or ICD 10 # _____

If applicable, please rate the level of severity of the student's diagnosis?

Mild _____ Moderate _____ Severe _____

Duration of Condition: Permanent _____ Temporary(Specify length of time) _____

Date of Diagnosis: _____ Date of last contact with the student: _____

2. How did you arrive at your diagnosis? Please check all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

- Behavioral Observations/Development History Medical History
 Rating Scales (e.g., CAARS, Brown ADD Scales for Adults)
 Neuro-Psychological Testing, Date(s) of Testing _____
 Psycho-Educational Testing, Date(s) of Testing _____
 Structured/unstructured student interviews
 Other (please specify) _____

3. Please indicate the level of impact the student’s disability may have in limiting the following major life activities: (**Please explain in question 4**)

Life Activity	No Impact	Neglible Impact	Moderate Impact	Substantial Impact	N/A
Communicating					
Concentrating					
Hearing					
Interacting with others					
Breathing					
Learning					
Making/Keeping Appointments					
Managing Distractions					
Managing Stress					
Meeting Deadlines					
Memorizing					
Performing Manual Tasks					
Reading					
Seeing					
Thinking					
Writing					
Other:					

4. For the major life activities checked on the opposite page, please provide an explanation of the functional impact of the limitation in an academic setting. _____

5. If applicable, please describe the relevant history of remediation (e.g. current medications, side effects of medications, other treatment plans and their effectiveness).

6. Please list any recommendations for accommodations you have for this student in an academic setting, if applicable. (Please note, recommendations will be considered in the interactive process, however final decisions will be determined by DS staff.)

7. Please provide any additional information that you think would be useful to know in working with this student. _____

Healthcare Provider Information

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon request.

Provider Name (PRINT): _____

Provider Signature: _____ Date: _____

Title: _____

License or Certification # _____ National Provider Identifier (NPI): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____