Western Oregon UNIVERSITY

Disability Access Services

503-838-8250 | 503-838-8721 (fax) | das@wou.edu

Disability Verification Form

Student Name: _____ **V#:** _____ **Date of Birth:** _____

The above-named student is requesting disability-related accommodations from **Disability Access Services** at Western Oregon University. Determination of eligibility for these services is partially based on disability verification, including diagnosis, functional limitations or impacts in an academic setting, and recommendations to mitigate those impacts.

Please complete this form in its entirety and attach any relevant diagnostic reports. **This form must be completed by a *qualified licensed professional.**

Diagnosis(es)

1. _____ **DSM/ICD Code:** _____
2. _____ **DSM/ICD Code:** _____
3. _____ **DSM/ICD Code:** _____
4. _____ **DSM/ICD Code:** _____

Functional Impacts

Please describe how the disability affects one or more major life activities (e.g. concentration, mobility, writing, etc.):

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Recommendations for accommodations in an academic setting to minimize impacts:

Certifying Professional Information

*A Qualified Licensed Professional must have expertise in the disability diagnosis and follow established best practices in the field.

Print Name: _____

Title:_____

License/Certification Number: _____ **Phone Number:** _____

Signature: _____ **Date:** _____

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Additional Information