La Sierra UNIVERSITY | *Office of Accessibility Services*

Disability Verification Request Form

This form is to be completed in full by a licensed professional.

Student Name:_____ DOB:_____

The above-named student has indicated that you are the licensed health professional who has personally seen them and who has suggested that having accommodations would be helpful in alleviating one or more of the identified symptoms or effects of the student's disability. So that we may better evaluate the request for this accommodation, please answer the following questions:

Diagnoses (Including ICD/DSM-IV/V codes): **Date:**

1._____ _____

2._____ _____

3._____ _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Partial remission ☐ Residual state

Condition: ☐ Permanent ☐ Temporary until _____ **Date of last visit:**_____

List current medications:

Medication	Dosage	Side effects

When was your initial contact with the student and how long have you been working with student regarding this disability?

Does the student require ongoing treatment? If so why, if not, why not?

Are there any functional limitations that impact academic performance?

What symptoms will be reduced by student having accommodations?

Is there any other information we should know?

Signature of Licensed Professional	Date of Verification
Print Name/Title	License Number
Address	Phone Number

Office of Accessibility Services. Email: oas@lasierra.edu