Office of Disability Services

DISABILITY SERVICES VERIFICATION FORM

21000 West Ten Mile Road C405
Southfield, MI 48075
Phone: 248.204.4100
Fax: 248.204.4115
Email: disability@ltu.edu

Documentation required to verify the condition and severity, includes completion of this form or provision of equivalent information on official letterhead to the Office of Disability Services by a medical professional with appropriate training and credentials. ODS may request additional documentation to illustrate a connection between the impact of the disability, the described barrier, and the requested accommodation.

If you already have documentation from your medical professional, this form may not be necessary. Please ask the Office of Disability Services if this form is needed. Documentation that may be acceptable in place of the Disability Verification form would include a 504 or IEP.

TO BE COMPLETED BY THE STUDENT:

Name: _____ Banner ID: _____

Address: _____ LTU Email: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Major: _____

I give permission to release requested information to the Office of Disability Services at Lawrence Technological University. My signature authorizes the Office of Disability Services to discuss any pertinent information with my physician, testing clinic, instructors or others.

Name of Medical Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Student Signature: _____

MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

A patient at your practice is a student at Lawrence Technological University and is requesting academic accommodations. Please complete the following sections in full. If additional space is needed, please attach additional documentation. Please include any relevant documentation (ex. Neuropsychological evaluation, audiology report, vision assessment, etc.).

Section I: Patient Information

Patient's Name: _____ DOB: _____

Diagnosis/Condition: _____

ICD-10 or DSM-V Code(s): _____

Date of diagnosis: _____

The condition is: ☐ Permanent ☐ Episodic ☐ Temporary

What is the severity of the condition? _____

When did you last see the student? _____

Is the student a current patient under your care? _____

Section II: Definition of Disability

The Office of Disability Services provides reasonable accommodations to students with diagnosed disabilities. A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."

The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, hearing disease, diabetes, Human Immunodeficiency Virus infection, intellectual or developmental disabilities, emotional illness, drug addiction, and alcoholism.

The term major life activities means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning and speaking.

Is the student disabled as defined above? ☐ Yes ☐ No

Does the student require medical/therapeutic equipment? ☐ Yes ☐ No

MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

Section III: Functional Limitations

What are the specific functional limitations resulting from the disability's impact on the major life activities in a learning environment? _____

_____

_____

_____

Are the functional limitations permanent? _____

_____

Is the patient receiving any prescribed treatment for the above condition(s)? _____

_____

Specific Academic Accommodations Recommended: Note: Please be a specific as possible (e.g., 50% extended time on exams and quizzes, reduced distraction setting, use of adaptive materials, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Additional information/comments: _____

_____

_____

_____

_____

_____

CONTINUED: MEDICAL VERIFICATION: TO BE COMPLETED BY HEALTHCARE PROVIDER

Healthcare Provider's Name: _____

Title: _____

Area of Specialty: _____

Type of License: _____

State of License: _____License Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

My signature verifies that I am or have been this student's treating health care professional and that all the contents above are true and accurate.

Signature: _____ Date: _____

PLEASE RETURN THE COMPLETED FORM TO:

The form can be turned in by mail, email or in person.

The Office of Disability Services, C405
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Southfield, MI 48075
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