DIVISION OF CAMPUS AND COMMUNITY ENGAGEMENT

THE UNIVERSITY OF TEXAS AT AUSTIN

Disability and Access · 100 West Dean Keeton St. A4100 · Austin, TX 78712-1093
community.utexas.edu/disability/ · (512) 471-6259 · FAX (512) 475-7730 · VP (512) 410-6644

Disability and Access
Verification Form
Deaf and Hard of Hearing

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the "Guidelines for Documenting Deaf and Hard of Hearing" for comprehensive documentation requirements and additional information. The acceptable age of the documentation is dependent upon the nature of the condition. In cases where the condition is permanent or unchanging D&A may require current functional limitation from a qualified provider. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact D&A at (512) 471-6259 with questions.

The information below is to be completed and signed by the student.

I request and authorize The University of Texas at Austin University Health Services (UHS), Counseling & Mental Health Center (CMHC), Disability and Access and/or my off-campus provider (name)_____ to release, fax, mail or discuss with each other information related to my registering with Disability and Access (D&A).

_____
Student Name EID

_____
Student Signature Date

Email Address: _____ Phone Number: _____

If the information above is left blank or is incomplete it may delay or prevent D&A from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.

The information below is to be completed and signed by the Provider.

1. Diagnosis: Please list all diagnoses and supporting numerical assessments of hearing.

_____

Degree of hearing loss without amplification: *Left*: _____ *Right:* _____

Degree of hearing loss with amplification (if applicable): Left: _____ *Right*: _____

a. Approximate age of diagnosis

- Child-approximate age:_____
- Adolescent-approximate age:_____
- Adult-approximate age:_____
- Unknown

b. Date of evaluation: _____/_____/_____

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

- Medical evaluation (x-ray, lab work, EKG, etc.).
- Standard audiology evaluation. Attach documentation.
- Other (Please specify):_____

b. Degree of hearing loss
- Within normal limits
- Mild
- Moderate
- Moderately severe
- Severe
- Profound

c. Type of Hearing loss:
- Conductive
- Sensorineural
- Mixed

Etiology:_____

d. Nature of Hearing Loss
- Progressive
- Stable

e. Current equipment used by student:
- Hearing aids
- Cochlear Implant
- FM System
- Other (please describe): _____

3. Functional Limitations

Does this hearing loss significantly **limit one or more of the following major life activities**?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Understanding conversational speech in one-on-one settings				
Understanding spoken language in group settings				
Comprehending recorded auditory/video content				
Ability to filter background noise				
Detecting environmental sounds				
Other:				

c. Please describe in detail any functional limitations that fall into the substantial range.

_____

_____

d. Special considerations: _____

_____

4. ***Accommodations***

a. Please mark whether student has utilized accommodations in the past.

- Yes Please describe: _____
- No
- Don't Know

b. (Optional) Recommended educational accommodations:

_____

_____

c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

_____

_____

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information on the next page. This form should be signed and returned via fax or mail to the D&A office at the address shown at the end of this document.

All documentation submitted to D&A is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

_____

State of License: _____ License Number: _____

Address _____

_____

Street or P.O. Box City State Zip

Phone: _____ Fax: _____

Please return this form to:

The University of Texas at Austin
Division of Campus and Community Engagement
Disability and Access
100 W. Dean Keeton St. Stop A4100
Austin, TX 78712-1093
Email: access@austin.utexas.edu
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Attach Provider Business Card Here