



**Disability and Access  
Verification Form for Students with  
Physical or Medical Disabilities**

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 Physical or Medical Disabilities” for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current documentation of the disability. The age of acceptable documentation is dependent upon the condition and the nature of the student's request for accommodations. Disabilities that are sporadic or change over time may require more frequent evaluations. Documentation that reflects the *current* impact on the student's functioning should be submitted. Present symptoms that meet the criteria for the diagnosis must be noted. 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, we ask that you complete the following questions, even if the material has already been included in your 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 relevant diagnoses.

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a. Approximate onset of diagnosis

- Child-approximate age: \_\_\_\_\_
- Adolescent-approximate age: \_\_\_\_\_
- Adult-approximate age: \_\_\_\_\_
- Unknown

b. Date of your last clinical contact with student: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**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.)
- Structured or unstructured interviews with student.
- Interviews with other persons (i.e. parent, teacher, therapist).
- Behavioral observations.
- Neuropsychological testing. Attach documentation.
- Psychoeducational testing. Attach documentation.
- Other (Please specify). \_\_\_\_\_

b. Evaluation Results: \_\_\_\_\_

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c. Present symptoms that meet criteria for diagnosis being noted:

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d. Current treatment being received by student:

- Medication management:

Current medications: \_\_\_\_\_

- Physical / Occupational therapy

Frequency: \_\_\_\_\_

- Other (please describe):

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e. Severity of symptoms

- Mild
- Moderate
- Severe

f. Prognosis of disorder:

- good
- fair
- poor

**3. Functional Limitations:** *Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.*

a. Does this condition significantly **limit one or more of the following major life activities?**

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				
Other:				

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

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d. Special considerations, e.g. medication side effects: \_\_\_\_\_

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e. **COURSE LOAD REDUCTION:** Is the student's condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

- Yes
- No
- I don't know

If YES please explain: \_\_\_\_\_

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**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  
Phone: (512) 471-6259  
Email: access@austin.utexas.edu  
Fax: (512) 475-7730  
VP (512) 410-6644

***Attach Provider Business Card Here***