DISABILITY AND ACCESS

THE UNIVERSITY OF TEXAS AT AUSTIN

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

Disability and Access
Verification Form for Students with a Temporary Disability

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 a Temporary Disability/Injury" for comprehensive documentation requirements and additional information. This documentation should provide information regarding the date of diagnosis, approximate durations of the condition, and the functional limitations with regard to how it interferes 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 following information is to be completed and signed by the Provider.

1. Current diagnosis, injury, and/or condition:

_____

_____

a. Date diagnosed: _____/_____/_____

b. Approximate duration of diagnosis, injury, and/or condition

- 2 weeks or less
- 2-4 weeks
- 4-8 weeks
- 8-12 weeks
- Unknown (please explain):_____

c. Current treatment/medication: _____

_____

2. Functional Limitations

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 current **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:				

3. ***Accommodations***

(Optional) Recommended educational accommodations, including course load reduction:

_____

_____

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 Student Affairs
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