Disability Verification – Confidential

4/3/12

Please send the completed form to Ashford University, Office of Student Access and Wellness
Fax: 866.251.5407 Email: access@ashford.edu

Student Information

First Name: _____ Last Name:_____ Student ID: _____

Please provide the following information in full to help determine reasonable accommodations to support the student:

Section A: Diagnosis and Limitations (Documentation of Disability)

Primary Diagnosis: _____ Dx Code: _____

Secondary Diagnosis: _____ Dx Code:_____

Limitations related to above diagnosis/ diagnoses as they pertain to the educational setting:

Impact upon (check all that apply):

☐ Concentration ☐ Emotional ☐ Hearing ☐ Memory ☐ Mobility ☐ Vision ☐ Wellbeing ☐Other:_____

Condition is: ☐ Stable ☐ Prone to Exacerbations

Duration of Disability: ☐ Permanent/ Chronic ☐ Temporary Anticipated Duration From: _____ To: _____

Section B- Accommodation Recommendations

Description of any medications, assistive devices, auxiliary aids, services, or accommodations currently in use or used in the past that may assist in the provision of educational accommodation(s):

Additional recommendations for accommodation(s) that may assist in accessing the educational environment:

Section C- Specific documentation of exacerbation of symptoms for special consideration

Dates impacted by exacerbation of symptoms/hospitalization: From: _____ To: _____

Description of the exacerbated symptoms and how they impacted participation in the educational environment (This may include, but is not limited to office visits, surgery, hospitalizations or medication changes):

Section D- Professional Certification

Signature of Certifying Professional:_____Title:_____

License number: _____Address:_____

First Name: _____ Last Name: _____ Phone: _____Ext._____

Stamp: Date: _____